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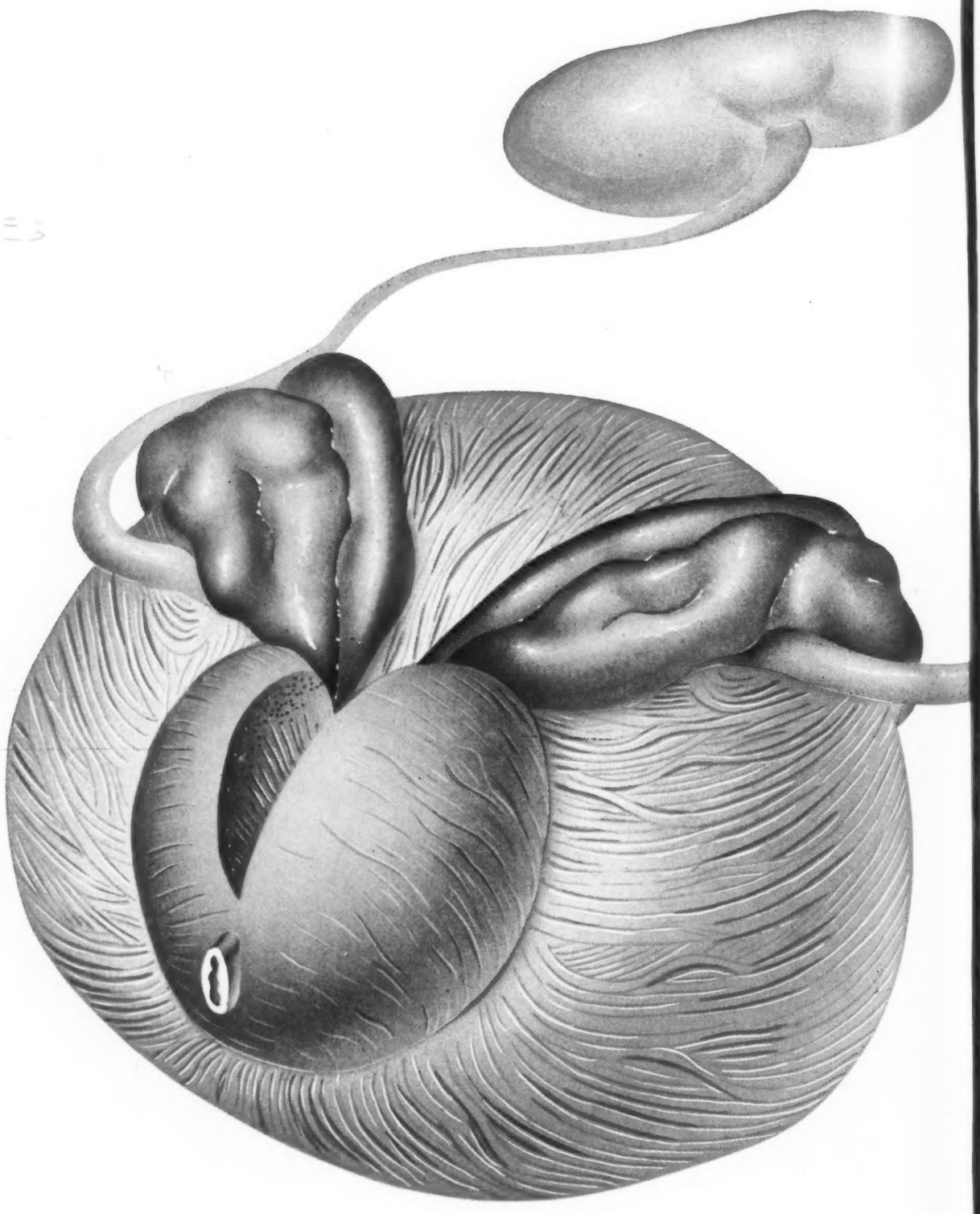
August, 1955
Volume 54
Number 8

The Journal

of the Michigan State Medical Society

KEEPING INDUSTRIAL AMERICA ON THE JOB

in severe urinary tract infections



THE JOURNAL
of the Michigan State Medical Society

VOLUME 54 AUGUST, 1955 NUMBER 8

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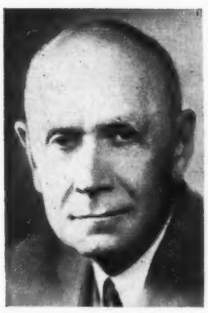

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AMA Washington Letter

THE MONTH IN WASHINGTON

For more than a year the administration has been attempting to work out a system of voluntary, contributory health insurance for Uncle Sam's two million or so civilian employes and their families. It would seem a simple thing to arrange, considering that most big employers have had similar plans in operation for years. At any rate, the plan is ready now for Congress to act on, but putting it together hasn't been easy.

First, there was the question of how to fit in the many already existing health insurance plans (some conducted by U. S. employe unions), and at the same time to offer coverage to government people working and living where no adequate insurance is being offered.

Also, there was wide disagreement as to how much of the premiums the federal government should pay; in private industry, employers' contributions range from a small percentage to the entire cost. U. S. employe unions naturally thought the federal government should set an example in generosity.

The program was first outlined early in the year. It then was put on the shelf for two reasons: a few refinements had to be made, and Congress first had to decide how big a pay raise it was going to allow U. S. workers this year before thinking about a fringe benefit, such as health insurance. The whole program was sent to House and Senate just at the start of the adjournment rush. with the realization that not much could be hoped for this session.

The plan offers U. S. employes the option of signing up with a local non-profit service or indemnity plan, providing 75 per cent of the workers in the particular operation vote for a particular plan and providing that plan is approved by the U. S. Civil Service Commission. If the employes can't get together, or if no adequate plan is available locally, they can sign up for a uniform national indemnity plan to be underwritten by one or more large national insurance companies and negotiated by the Civil Service Commission. The proposed law itself lists specifically the original benefits that must be provided by the uniform plan, but authorizes the Commission to readjust them.

Regardless which type coverage the employe selects for himself and his family, the federal contribution would be figured the same way. It could not exceed one third of the total premium, or $19.50 annually for a single person or $52 for one with dependents, whichever figure is the lesser. If the uniform plan is chosen, the single employe could not be charged more than $39 annually, or the one with dependents more than $108 annually. But under any other plan, the employe would pay the difference between the U. S. contribution and the premium cost.

A system of major medical cost or catastrophic insurance also would be provided. Under it the employe would have to pay the first $100 of cost, after benefits of the basic policy had been exhausted, before major medical cost benefits would become available. From that point on, until $10,000 had been paid by the company, the employe would have to pay only 25 per cent.

* * *

The first major medical bill enacted was the extension for another two years of the doctor draft act, which for five years has been furnishing the Armed Forces and the Public Health Service with most of their doctors. Before passage, two changes were made in the law. The maximum age for induction was dropped five years. Under the old law a man could not be taken against his wishes after he had reached his fifty-first birthday; the new law reduced it to his forty-sixth birthday. Also, the law no longer applies to physicians and dentists who have reached their thirty-fifth birthdays and who have been rejected for a medical or dental commission at any time solely on the grounds of physical condition.

Defense Department points out that the man has to be able to demonstrate that he actually applied for a medical or dental commission and was rejected; a 4-F draft board classification is not sufficient. The department also said that the law will not result in the discharge of men already in uniform, even though they could not be inducted under the new law.

As adjournment approached, prospects were that not much more medical legislation would be enacted this session. Most likely of success was a proposal for U. S. grants to states to help finance Salk vaccine costs; the states would decide the priority of age groups, but in a public program there could be no "means test" to determine whether a family could afford to pay. Under this plan the states would receive a certain amount as a straight grant, based on the state's economic need and the number of uninoculated children. If they wanted to put up dollar-for-dollar, the states also could draw on a second account. The bill does not set any limit on U. S. appropriations.

Two other possibilities were bills for a national survey of mental illness (which passed the House early in the session), and for U. S. grants to medical schools.

You and Your Business

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
Civic Auditorium—Pantlind Hotel, Grand Rapids
Wednesday-Thursday-Friday, September 28, 29, 30, 1955
YOU are invited to attend the Ninetieth

CRIPPLED-AFFLICTED CHILDREN AND DELINQUENT BILLING

Delinquent billings from hospitals and doctors of medicine for service to afflicted and crippled children performed between July 1, 1954, and June 30, 1955, will now be paid. Permissive legislation passed by the 1955 Michigan Legislature permits this reimbursement.

The Legislature this year also extended the sixty-day billing clause, in effect for many years, to ninety days. Doctors and hospitals are now permitted ninety days after services are rendered in which to furnish billing for medical service and hospital care to crippled and afflicted children.

Bicillin and Rheumatic Fever

The Michigan Crippled Children Commission will inaugurate a program next autumn covering children coming under the Michigan Afflicted Children's Act having rheumatic fever. The doctor of medicine will be paid $3.00 by the Commission for each injection of bicillin, the drug being supplied free for all cases, afflicted children and others, by the Michigan Department of Health. Physicians may order a supply of bicillin from the Michigan Department of Health Laboratories, but it must be kept refrigerated.

Detailed information on the new crippled children program will be mailed by the Commission to every MSMS member in September or October.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF THE COUNCIL

Meeting of June 15, 1955

Seventy-six items were presented to the Executive Committee of The Council at its June 15 meeting in Charlevoix. Chief in importance were:

- **Personnel of Committee on Arrangements** for 1956 Michigan Clinical Institute, including the Program Committee, was approved.
- **Salk Polio Vaccine.**—K. H. Johnson, M.D., Lansing, Vice Speaker of the MSMS House of Delegates and a member of the State Advisory Committee on Polio Vaccine Distribution, reported that a meeting of this committee was scheduled in Lansing for June 17; he read a statement drafted for possible presentation. The Executive Committee congratulated Dr. Johnson on his appointment to this State Committee and approved the substance of his statement.
- **Committee Reports.**—The following committee reports were presented and given consideration: (a) Permanent Conference Committee, meeting of May 18; (b) Mental Health Committee, May 26; (c) Study of Periodic Health Examinations in Hospitals, June 1; (d) Arbitration Committee, May 13; (e) Awards Committee, June 15; and (f) Committee on Mediation, Ethics and Grievance, June 15.

MEDICAL MEETINGS AND CLINIC DAYS

A list of known medical meetings and clinic days, sponsored by county medical societies and other physician groups in Michigan, follows:

1955		
September 12-15	Twentieth Annual Congress—International College of Surgeons (United States and Canadian Section)	Philadelphia, Pa.
September 26-27	Annual Session of the House of Delegates (MSMS)	Grand Rapids
September 28-30	MSMS Annual Session	Grand Rapids
September 28-30	Mississippi Valley Medical Society	St. Louis, Mo.
Sept. 30-Oct. 1	American Medical Writers Association	St. Louis, Mo.
October	Clara Elizabeth Fund for Maternal Health and Genesee County Medical Society	Flint
October 14	Michigan Cancer Conference	East Lansing
October 17-19	Eighth Annual Scientific Meeting—Detroit Institute of Cancer Research.	Detroit
Autumn	MSMS Postgraduate Extramural Courses	State-wide
November 1-3	International Symposium: Units of Biological Structure and Function. Henry Ford Hospital.	Detroit
November 9-10	Third Annual Midwest Conference on Rheumatic Diseases. Henry Ford Hospital	Detroit
November 9-10	Ninth Annual Fall Post-Graduate Clinic—Michigan Academy of General Practice	Detroit
1956		
March 7-9	Michigan Clinical Institute	Detroit
April 11	Tenth Annual Cancer Day	Flint

- **Wm. A. Hyland, M.D.,** Grand Rapids, Chairman of Michigan Delegates to AMA, presented report on the June 1955 AMA session in Atlantic City, which was accepted with thanks.
- **Basic Science Act Amendments**—Report was given that HB415, approved by the Michigan State Medical Society as passed by the Legislature, is now on the Governor's desk for signature.
- **Dr. and Mrs. W. S. Jones,** of Menominee, presented to the Beaumont Memorial on Mackinac Island a special hand-made wrought-iron grill to protect the precious Beaumont books previously contributed to the Memorial by President-Elect and Mrs. Jones. The Executive Committee of The Council placed upon its minutes a vote of deep apperciation for the continued generosity of the Joneses.
- **Matters of mutual interest** were discussed with Dr. A. E. Heustis, Michigan Health Commissioner, including legislative program, poliomyelitis vaccine, and Annual Conference of Physicians and Schools. The Executive Committee commended Dr. Heustis for requesting the creation of the State Advisory Committee on Polio Vaccine Distribution.
- **Invitation from the Michigan State Pharmaceutical Association** to send representatives to meet with MSPA and Smith, Kline and French Laboratories to discuss substitution of drugs was accepted—the MSMS representatives being the members of the Liaison Committee with MSPA.
- **H. W. Bird, M.D.,** Detroit and **A. T. Rehn, M.D.,** Lapeer, were authorized to attend the second Annual Conference on Mental Health at AMA, Chicago, November 18 and 19 as MSMS representatives; **B. L. Masters, M.D.,** Fremont, was appointed MSMS representative to attend Michigan Rural Health Conference Planning Committee meetings.
- **Legal Counsel J. Joseph Herbert** presented opinions on two matters, one re salaries of house physicians and residents in hospitals.
- **The thanks of the Executive Committee of The Council** were expressed to Dr. and Mrs. G. B. Saltonstall for opening their home to the Executive Committee of The Council for this meeting.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 33rd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held August 28-September 2, 1955, inclusive, at the Hotel Statler, Detroit.

Scientific and clinical sessions will be given August 29, 30, 31, September 1 and 2. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive secretary, Dorothea C. Augustin, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

PR REPORT

THE MEDICAL ASSOCIATES project of MSMS has attracted nationwide attention, and at the request of the American Trade Association Executives was entered in the 1955 competition for ATAE awards for distinguished service. Steps taken by MSMS in launching and executing the long-range program were outlined in detail as an example of service to both the public and the medical profession, and then the outline was submitted to a distinguished committee of judges headed by the Secretary of Commerce. The project has been successful in several ways, notably in interesting the M.D. in increasing his efficiency and broadening his service to patients, by using medical associates, and in recruiting young men and women for the many fields of medical associates by selling them on the career opportunities through the use of many channels of information and PR techniques.

Winners of distinguished service awards are to be announced at the 35th Anniversary Meeting of ATAE on Mackinac Island in early August.

MICHIGAN RATES MENTION twice in the new AMA brochure "Community Efforts Provide Medical Facilities," produced by the Committee on Medical and Related Facilities of the Council on Medical Service. Ralph A. Johnson, M.D., of Detroit, is chairman of the committee. Robert L. Novy, M.D., of Detroit, is a member.

The Doctors' Clinic at Hillman and the Onaway Health Center both rate two pages as "good examples of successful community activity" in providing medical facilities and securing an M.D. for an area lacking medical care. Six other such projects are cited; two each in South Dakota and Kansas, and one each from Montana and Florida.

The brochure is designed as a "how-to-do-it" booklet for citizens of other communities seeking medical service. It lays out each step taken by the eight representative communities in planning, financing and constructing facilities through community-wide participation, and subsequent activities which brought an M.D. to make use of the facilities. The Michigan Health Council is mentioned prominently for the co-operation of its M.D. Placement Service.

Incidentally, Michigan Health Council, with guidance from MSMS, is preparing a new brochure explaining the operations of the M.D. Placement Service to serve double-duty (1) by helping communities in need of medical service map out a campaign to secure an M.D., and (2) in making the services of the placement service known to M.D.'s seeking a location.

A NEW TELEVISION SERIES presenting "specific accomplishments in the field of medicine brought about by the teamwork of modern medical research, education, and practice" will have its premiere over ABC-TV on September 12. Entitled "Medical Horizons" and sponsored by Ciba Pharmaceutical Products of Summit, N. J., the programs will be seen from 9 to 9:30 P.M. each Monday, with WXYZ-TV, Detroit, the Michigan outlet. Live remote telecasts from medical institutions and research centers throughout the country will be featured in the 26-week series. A tentative line-up of 45 stations is scheduled to carry the program.

The theme of the new show is similar to that of the 1955 Michigan Clinical Institute in Detroit last March, when the teamwork between the pharmaceutical industry, the pharmacist, and the M.D. in promoting medical progress was highlighted in a series of addresses and special events.

A SUMMARY OF PR ACHIEVEMENTS and the PR outlook for the future will be found elsewhere in this issue within the Annual Report of The Council of MSMS.

The MSMS road map for upcoming PR activity will be developed at the semi-annual meeting of the PR Committee, under chairmanship of C. Allen Payne, M.D., Grand Rapids, scheduled for Flint on Sunday, August 28. Plans will be presented for approval to The Council at its September meeting in conjunction with the 90th Annual Session in Grand Rapids.

METICORTELONE possesses antirheumatic and anti-inflammatory effectiveness and hormonal properties similar to those of METICORTEN,[1-5] the first of the new Schering corticosteroids. Both are three to five times as potent, milligram for milligram, as oral cortisone or hydrocortisone. METICORTELONE and METICORTEN therapy is seldom associated with significant water or electrolyte disturbances.

METICORTELONE is an analogue of hydrocortisone, as METICORTEN is of cortisone. The availability of these new steroids, both discovered and introduced by Schering, provides the physician with two therapeutic agents of approximately equal effectiveness.

METICORTELONE is now available as 5 mg. buff-colored tablets, scored, bottles of 30 and 100. In the treatment of rheumatoid arthritis, dosage begins with an average of 20 to 30 mg. (4 to 6 tablets) a day. This is gradually reduced by 2.5 to 5 mg. until daily maintenance dosage, which may be between 5 to 20 mg., is reached. The total 24-hour dose should be divided into four parts and administered *after meals and at bedtime*. Patients may be transferred directly from hydrocortisone or cortisone to METICORTELONE without difficulty.

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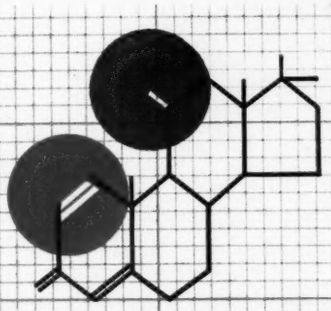

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  eye disorders[5]
  certain skin disorders such as disseminated lupus erythematosus,[13,14] acute pemphigus,[13,15] atopic dermatitis[15] and other allergic dermatoses
- more active than hydrocortisone or cortisone, milligram for milligram
- relatively free of significant water or electrolyte disturbances [5]

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Editorial Opinion

REOPEN THE DOOR!

America has always been the land of promise and challenge and opportunity. To its shores have come the peoples of the world, literally the world, seeking opportunity—the chance to live in freedom, to raise their families, to speak without fear of punishment, to meet their fellow men without the hazard of an informer and to worship according to their custom. This amalgam of people seeking liberty and a chance has made America.

There are medical schools in other countries. They train young men and women to succor the ill and to seek out the cause and the cure of disease. Many of these graduates look toward our American shores for opportunity. They seek internships in our hospitals. It seems to be recognized that they should be granted this opportunity: the Federal government permits them to enter this country in two special categories for this year of internship. Some enter as Fulbright scholars on funds underwritten by our own tax dollar. Others come to us on a special visitor's visa permitting entry for one year, using their own funds to pay for this chance to increase their sum of medical knowledge.

They have been welcome in many hospitals in many states. As long as our own medical schools are unable to fill the deficit between the number of medical graduates and the number of hospital internships approved by the various accrediting agencies, there will be need for them. There is some evidence that they have been exploited in some hospitals.

The Michigan State Board of Registration in Medicine takes a dim view of the graduate of the foreign medical school seeking an internship in a Michigan hospital. It has formulated an administrative ruling, effective July 1, 1955, to the end that the graduate of the foreign medical school, having gained entrance to America either as a Fulbright fellow or on the special one-year visa for the specific purpose of obtaining an internship, must pay a fee of $50 and be subjected to a special screening examination before he may start an internship in a Michigan hospital.

Several things are to be pointed out. Administrative rules of the Board are not law, despite the efforts of the Board to make them look like law. This screening examination is in no sense the licensing examination provided for in the Medical Practice Act and carries no authorization for the intern to practice medicine, surgery or midwifery. The examination is conducted by savants of the two medical schools in the state with the avowed intent of determining whether the appellant should be permitted to start an internship—obviously using criteria determined by present teaching practice in these two medical schools. The fee works an unusual hardship on the foreign graduate entering on the special visa because it must come from his limited personal purse. The Board is also trying to make its administrative rule retroactive from the published date—that is, to affect interns who have been serving in Michigan hospitals for months prior to the effective date: but the Board has tried to make earlier administrative rulings retroactive also: that's the way the Board works.

An administrative official of the Board has said, in connection with another problem several months ago, that it is improper to criticize an action of the Board. When the time comes that a citizen cannot challenge a decision of an appointive board, then we have lost something in America—not the least of which is extending to the graduate of the foreign medical school the opportunity of expanding his store of medical knowledge during an internship in one of the hospitals of the State of Michigan.—WILLIAM BROMME, M.D., *Detroit Medical News.*

THE ANAMILO CLUB

"The ordinary things we do immediately, the difficult take more time, the impossible take a little longer."

Not long ago a patient developed an asymptomatic, persistent hoarseness which upon further investigation proved to be carcinoma of a vocal cord. The only hope was to have the larynx removed. This was a heavy blow.

While this patient was in the hospital being prepared for the operation, he was visited by another man who had been through the anticipated surgical procedure. The surgeon had arranged the visit.

This visit proved to be a turning point in the patient's attitude or philosophy about the ordeal. It brought him new hope. To be deprived of his voice seemed very depressing, well nigh defeating. Then unexpectedly a newly found friend had taken enough interest in him to call on him in the hospital and to encourage him by proving that one can go on and that one can learn to speak again.

This gentleman was a member of the Anamilo Club—Greek for "I speak again." The organization in this community was formed by five or six beginners and now has expanded to include 275 members all of whom had cancer of the larynx and been larvngectomised. All of them have

(Continued on Page 916)

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more tissue oxygen
improved muscle metabolism
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1. Pomeranze, J. et al.: Angiology, June, 1955.
2. Freedman, L.: Angiology 6:52, Feb. 1955.

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THE ANAMILO CLUB

(Continued from Page 912)

learned to speak again using the esophageal voice which consists of swallowing a small portion of air, not all the way into the stomach but into the upper esophagus, and speaking on this column of air as it is regurgitated.

Some time ago these men got together to help each other learn to use the esophageal voice. The most proficient among them became the teacher and drilled the others including new students as they came into being until "the voiceless men" became almost vociferous when they spoke in unison at class.

At a later date the Detroit Cancer Society became the sponsor of the Anamilo Club as the first full-time speech school in the country for laryngectomised patients and to help them master the slightly complicated technique of learning to speak again by using the esophageal voice. At the present time there are twenty-two schools throughout the United States.

The Anamilo Club speech classes are great morale builders. The previously dejected students really learn to speak once more and soon thereafter resume their previous work or sometimes a different work and enter into a wide range of social life. They visit other patients in the hospital and in their homes. They establish a rapport among themselves. They assemble at the Anamilo Club and learn to be useful citizens once more. This enterprise has great emotional appeal if all the potentialities are considered.

If there is a hospital in this community where the staff members are not familiar with the important rehabilitational work done by the Anamilo Club, they would do well to consider a staff meeting devoted to this subject and see the short film describing their work. It is fascinating.

This is a praiseworthy project—CHARLES SELLERS, DETROIT MEDICAL NEWS.

MEDICAL OPPORTUNITIES UNLIMITED

The young doctor finishing medical school today has professional opportunities unlimited. A generation ago, as recent as that, it was the fortunate ones who were able and were given the opportunity of graduate medical training in their own community or even in this whole country. The method of postgraduate study and specilization then was accomplished for the most part by study in one of the then great European medical centers. When we started practice and went to medical meetings all that was needed by a speaker to establish his authority in medicine was to begin with "when I was in Europe."

Today this is reversed. In Detroit, we have residents and fellows in training in our hospitals from throughout the country and from Europe and Asia and Africa. This is duplicated all over our nation; on reading the journals we see contributing men listed as continuing their training whose home residence is given as the major cities and universities abroad.

In the current issue of *Circulation* among contributors from American hospitals and medical schools who came from abroad to study here are a doctor from Florence, Italy; one from Kingston, Ont., another from Johannesburg, South Africa, and one from Bern, Switzerland. This in a single issue.

And in our own city in the Exchange Visitor Program under the State Department there are right now twenty-seven doctors finishing a year of training in Detroit Receiving Hospital, the teaching hospital of Wayne University. These doctors furthering their training in our hospitals are:

Radiology—4; one each from Mexico, Germany, Italy and Austria.

Anesthesia—5; one from China, two Canada, two Japan.

Surgery—6; from West Indies one, two from Japan and three Canada.

Gynecology—5; one each from Iran, Spain, the Philippines, Canada and Lebanon.

Otolaryngology—1; from South Africa.

Pathology—1; from West Indies.

Ophthalmology—3; one each from Iran, Mexico and Canada.

Dermatology—1; from Cuba.

Medicine—1; from Italy.

A medical graduate from either of our two great medical schools in Michigan has his choice of hospital residency and fellowships in teaching hospitals and hospitals with teaching programs and medical school affiliations in his own community giving training in any specialty.

The United States is now the place for postgraduate training. Being close to greatness we sometimes lose perspective.

The young doctor in America, in Detroit, has medical opportunities unlimited.—DAVE SUGAR, *Detroit Medical News*, July 4, 1955.

END THE DOCTOR DRAFT

Further extension of the practice of conscripting physicians and dentists up to the age of fifty-one would be excusable if the nation were at war, or if it could be clearly shown that there is no other way to meet the medical needs of the armed forces. Neither of these conditions exists.

The real reason for the extension of the doctor draft is disgraceful. Nearly half of the authorized positions for career medical officers are unfilled. Young doctors are repelled from a job which offers salaries below civilian levels, which requires

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END THE DOCTOR DRAFT

(Continued from Page 916)

them to waste much time in duties not connected with their profession, and which keeps most of them at work on patients who are not members of the armed forces.

There is no argument about the necessity for having enough physicians and dentists to care for the needs of soldiers, sailors, airmen, and the dependents of servicemen stationed in foreign countries. These needs, however, could be supplied by career officers if the career service were made slightly more attractive and by the new medical school graduates who, like all other young men, are subject to conscription under the general draft law.

The need for drafting older doctors, including some who have already had a tour of duty in the armed forces, arises from the policy of providing free medical service to nearly 3 million dependents of servicemen and more than a million civilian employes of the defense department. Most of these nonservice patients are in areas well supplied with civilian physicians. If medical service must be supplied free to dependents and other civilians, why can't the Defense Department contract directly with local hospitals and doctors, or pay the premiums for health insurance to cover the costs?

The government is not drafting plumbers to work at subunion pay scales in the homes of military men and their dependents, nor has it seized factories to make free clothing for dependents and civilians. The doctor draft is unjust. Its extension would mark the first time in our history that any group of citizens had been singled out for conscription in peacetime because of their professional skill.—*Chicago Tribune.*

STATEMENT ON METHOD OF INTRODUCTION OF SALK VACCINE

Following is a statement adopted by the Council of the California Medical Association, May 4, 1955.

The Council of the California Medical Association has been deeply disturbed by circumstances and events surrounding and following widespread introduction of antipoliomyelitis vaccine (Salk vaccine) in April, 1955. The tragic occurrence of poliomyelitis even in a relatively small proportion of the children injected with the vaccine indicates that the time has arrived to stop, to think, to analyze and to carefully consider how the present situation developed.

As a result of past experience, some of it bitter, with new prophylactic and therapeutic measures, a tacit or explicit policy has long been in force among medical men with regard to general acceptance of a new product or method: The policy entails a sequence of cautious and preliminary exploration, then publication of results in medical journals and gradual accumulation of data bearing equally on efficiency and safety. It was for this purpose that the Council on Pharmacy and Chemistry of the American Medical Association was formed.

Certain examples of the wisdom of this approach and of danger in its neglect can be cited. The development of diphtheria toxoid in its present satisfactory form followed several years of trial and error. On the other hand, the use of yellow fever vaccine, hastened by the exigencies of World War II, was followed by totally unexpected complications of homologous serum hepatitis, affecting more than 20,000 persons, many of whom died. This led to revision of the method of preparing the vaccine and to its present safety. In the case of poliomyelitis, two supposedly safe vaccines (Kolmer and Brodie) were put to human use in the 1930's. With both of these vaccines paralytic poliomyelitis occurred in the ratio of approximately one to 1,000 of the persons vaccinated, and usually the disease involved first the inoculated extremity or extremities.

In the present instance the National Foundation for Infantile Paralysis and advisory groups decided to by-pass a long period of trial and error by making a single, very large-scale field trial in 1954 and having results studied by the best-known methods of collection of data and statistically appraised by experts using fully objective techniques. This study was culminated in the Francis report announced April 12, 1955, at Ann Arbor, Michigan. The field trial of poliomyelitis vaccine was conducted with great thoroughness and care and the results appear to demonstrate that vaccination with killed poliomyelitis virus produces a considerably increased degree of protection against the disease. The study indicated that this protection, while not complete, is sufficient to give promise that the use of the vaccine should reduce the incidence of poliomyelitis. The magnitude and accuracy of the collected data and scrupulous performance of analysis leave little room, if any at all, for criticism; and for this Dr. Francis and his colleagues deserve the highest credit. The same may be said of the preliminary work of Dr. Salk and his colleagues.

Certain features of the program, however, are open to serious criticism. They have already led to serious and unforeseen difficulties and have already interfered to a considerable degree with continuance of the program. The results of the vaccine trials were announced under the aegis of a lay organization to a relatively small number of interested professional and lay persons at the University of Michigan. Simultaneously the results were announced to the general public by radio and television and by the press. Since the basic charts used in the report were illegible on television in some areas and on some television receivers, many

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STATEMENT ON METHOD OF INTRODUCTION OF SALK VACCINE

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persons in the medical profession had only the condensations of press, radio and television commentators available to them. They did not soon enough or long enough have access to the exact and fundamental data of the full report. Copies of the original report were available for only a few of the many public health officers throughout the country who were responsible for conducting the free vaccination of school children, although the program, as prescribed by the Foundation, was to start at once. This objection also applied with even more force to practicing physicians, who were immediately placed under urgent demands for vaccine by parents of their patients. They were wholly dependent on public media of communication for appraisal of their medicolegal responsibilities.

Nationwide planning was immediately developed to administer the vaccine to first and second grade children in school, and these plans were virtually completed before there was any opportunity for many of those responsible for regional, state and local planning to have any personal knowledge of the exact content of the report of the field trials. This was particularly unfortunate, since it was revealed at the meeting in Ann Arbor that the composition of the vaccine and also the additive used for antiseptic, preservative and enhancing purposes, as well as the time schedule for its administration, had not been fully standardized. Even at the time of the public announcement, some of these factors were still undergoing changes.

Furthermore, there was not available to physicians and public health officials scientific evidence concerning the composition and safety of the vaccine. The decisions concerning the number of safety tests of individual lots and pools were made on advice and counsel of a group of outstanding experts. Tests that must be carried out to establish the absolute harmlessness of any method of immunization before it is put into use are time-consuming and the results must be carefully considered. Hence it is not feasible for the individual physicians or the health officers who are trusted with the health of the people to make such tests and studies as individuals. Responsibility of this magnitude requires profound searching appraisal by national groups of scientists and physicians.

In the present case, it would appear that a desire to bring the vaccine onto the market and to use it before the closing of schools may have created conditions that led to by-passing some of the time-honored scientific steps in professional education and evaluation and to alteration of some of the safety precautions required in the preparation of the vaccine. With a product of a single manufacturer there have been a number of paralytic sequelae to the vaccinations. Present evidence suggests these were, in effect, "inoculation poliomyelitis" rather than spontaneously occurring disease, although full investigation of this question is still to be carried out.

While a committee of virologists and epidemiologists of unquestionable authority has unanimously declared its belief that the vaccine now available for use is entirely safe and satisfactory, it remains to be determined whether the present difficulties with the vaccine are due to a defect in laboratory precautions or to a fundamental defect in the method itself.

In summary, physicians of California are co-operating and will continue to co-operate to the fullest extent with local, state and federal health agencies to safeguard the health of our people and the ultimate control of poliomyelitis.

The Council of the California Medical Association disapproves and condemns the methods of announcing the Salk antipoliomyelitis vaccine. It disapproves the contrived publicity with which the announcement was made and the fact that there has not to date been an opportunity for general scientific discussion of the value of the method. It further disapproves nonprofessional agencies' deciding the time and the means of reporting matters of a scientific nature and it disapproves such agencies' deciding the measures which should be employed in the further use of medical materials or methods.

It is urged that the National Research Council immediately undertake an extensive study of every phase of the manufacture and testing of the vaccine.

The C.M.A. Council believes that, in accordance with traditional scientific standards and practices, the use of this vaccine, as well as all other therapeutic and prophylactic agents, must be left to the judgment of the individual physician.—*California Medicine,* June, 1955.

It has been well established that there is a definite hereditary tendency to retinoblastoma.

* * *

Radiographic examination is a helpful adjunct in diagnosis, since calcium deposits can be detected in almost all retinoblastomas.

* * *

Twenty per cent or more of all retinoblastomas are bilateral.

* * *

Cancer of the digestive tract constitutes 23 per cent of total cancer in both sexes.

* * *

Cancer of the upper digestive tract occurs as follows: esophagus, 1 per cent; stomach, 6.6 per cent; liver and biliary passages, 1.8 per cent; pancreas, 1.8 per cent, and small intestine, 0.2 per cent.

The JOURNAL

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Relationship Between the Physician and Industry

By Thornton I. Boileau, M.D.
Detroit, Michigan

THE CHANCES are more than even that the patient who seeks the counsel and help of a physician, in this bustling industrial giant of Michigan, is employed in some job with one of the many industries that keep the economic life-blood flowing. Whether this job be large or small, it is of such importance that he must spend half of his waking hours, or one-third of the average day, subject to the environmental, physical and mental stresses that the particular occupation demands.

It matters not whether he is a high salaried executive of a corporation or an hourly rate laborer; the impact of the many factors with which he comes in contact each day, on his physical state, cannot be ignored. In the difficult field of medical diagnosis, consideration of the work history will often lend the key to an otherwise puzzling problem and enable the doctor to serve more surely the most important individual in the practice of medicine—the patient.

Failure to consider the occupation factor in not only the diagnosis but also in the care of our patients, as they return to their jobs, deprives us of one of the most basic instruments in the treatment, rehabilitation and preventive aspects of medicine.

Physical Condition and Occupation

The limitations placed upon physical ability by heredity, development, injury or disease are not quite as easily measured as intelligence. However, whether his work is full-time industrial, a percentage industrial or entirely private practice, the physician is able to give a rather accurate evaluation after a fair opportunity to examine a patient. It is an important opinion to the man, his family and his employer, for it may determine not only the type of work that he may do today, but serve as a guide so plans can be made for the future. The findings properly correlated with his work activity may determine, to a great extent, the useful life expectancy.

It has been the custom in industry, over a period of years, to do pre-employment examinations. However, it must be recognized that early impetus was given, not so much by the medical profession, or by management, as by the advent of the State Workmen's Compensation Laws. With time and experience, it became evident that the routine pre-employment examination, originated as a defensive mechanism, could be a constructive bond between employer and employe. The scope was enlarged, and the pre-employment became the pre-placement examination, where the physical assets were weighed as well as the physical defects. There were fewer men rejected; more and more were now found employable.

Unfortunately, the physical state is a constantly changing one and in order to keep abreast of it, periodic physical examinations are a "must." In the field of industrial medicine, it has been recognized for some time that periodic examinations offer a continuity of records that, by comparison, will permit earlier detection of disease processes and thus earlier treatment. Changes in the physical index may dictate changes in occupation.

The number of cases referred to the family physician by the industrial physician are legion, and they form one of the strongest links of interdependence between the two. The accumulated information from the files of an industrial medical department or the records of the family physician is a basis for co-operation between members of

the medical profession that will benefit all concerned.

Job Placement

The knowledge gained while a man is under the physician's care and treatment would not be fully utilized if it were not applied, in a measure, to the field of preventive medicine, and proper job placement is just that. Fortunately, it is not necessary to restrict the activity of the great majority of our patients, but there are instances when it must be done.

The diabetic patient on insulin, the epileptic, the hypertensive with vertigo, or the patient with postcoronary thrombosis should not be working on high places or on machines where the safety of themselves or fellow employes is endangered. Marked visual or hearing loss would not be qualifications for a crane operator or electric truck driver. A patient with a known history of allergy should certainly be cautioned to avoid contact with solvents, synthetics and certain dusts. Although there are a multitude of applications for job placement in specific cases of physical defect or disease, we have another group that is equally important.

It is the fellow whose general physical makeup or nervous temperament renders him unsuitable for certain types of work. The employe who does not react quickly enough to situations or allows his attention to wander repeatedly will often compile an impressive first-aid record before he is seriously injured. To move the man before serious injury occurs is to save him from himself. The machine age is rather harsh in its treatment of the too-quick or too-slow.

The task that falls upon management to carry out the recommendations of the physician today is not an easy one. The obstacles in its path when it comes to job placement are many. Sometimes the industry has few light jobs available, or the occupational variations are limited. Union contracts generally do not permit job changes out of line of seniority. Occupational or departmental seniority further complicates changes. A reduced production schedule necessitates layoffs that require a man to return to his old job.

The most difficult assignment often is to convince the employe that he should not do certain types of work. This is particularly true of the older man who has done the same job for years and will not concede that he is no longer Olympic material. He will generally believe the family physician, if no one else. With all this, there is usually a job that each man can do with safety, efficiency and due regard for his health.

The Physician and Management

Certainly, there have been times when every doctor has wondered whether his note to industrial management regarding a patient is ever considered. You may be assured—it is. Aside from humanitarian factors, information that allows better job placement also results in fewer accidents, more efficiency and less absenteeism. In a competitive private enterprise economy, these factors are most important.

When we consider that more than three-fourths of all industrial establishments employ less than a hundred people in a plant, it is evident that much of our attention should be directed toward the smaller industries. The small manufacturer cannot afford an elaborate medical setup, but if he is to stay in business, the cost of lost time from the job, due to illness or injury, must be kept down. In many communities, the local physician will find that he not only cares for the families of employes but handles the examinations and injuries for a number of small plants as well. It is in this role that the doctor may first evidence his interest by assisting management in setting up a practical first-aid facility in keeping with the size and needs of the specific industry.

It may be only a simple medical chest, placed in the care of a few selected for training in basic first-aid principles, but nevertheless a start in the right direction. In a larger concern, it could be more practical to establish a First Aid with an industrial nurse in charge, who then may rely on the doctor for advice and guidance as problems arise. Management can be helped in its efforts to look out for the best interests of its employes and at the same time maintain economy in operation. When an industry fails to meet competition, it has little need for medical services. It ceases to exist.

At one time, it was only the production worker who rated an examination, but as the public became more health conscious, it occurred to the heads of corporations that the men guiding their destinies were valuable enough to warrant periodic examinations. And so the first contact with members of management may be in the course of an executive examination. As practical men, they

will quickly see the advantages of a sound medical policy if the doctor will take the time to explain such a program.

Most points of disagreement are based upon a misunderstanding of the other man's problems. And the doctor-management relationship is not immune to such misunderstanding. However, there are few areas where close co-operation will do more good. When a problem case arises, the industrial physician should be contacted if the patient is employed by a large corporation, or the member of management in charge of personnel if the patient is employed by a small industry. The diagnosis, if permissible, and the recommendations of the attending physician, serve as a guide to the employer, who in turn may advise the doctor as to the type of work the man has been doing and jobs available. The interest of the patient has been kept foremost, and he will be grateful to both.

Familiarity with Job Demand

In almost every community, the doctor passes factories, large or small, on his daily rounds and may see the bustling activity or hear the roar of machines, but may have little idea of what actually goes on inside. However, it is within these plants that a large percentage of his patients or members of their families are working. It is necessary to know the physical demands of local industrial jobs if we are to understand what the man really does. It may be surprising to learn that a hog-ring clipper, spearman, doghouse welder, or merry-go-round operator is not exactly the type of job the words imply. A plant tour will not only prove interesting, but will enable the doctor to evaluate more carefully the history obtained from a patient, question with more accuracy and make sound recommendations. To conduct preplacement examinations without some knowledge of job demand is akin to choosing contestants without knowing whether they are to compete in weight lifting or be on the rifle team.

Many patients quite honestly, for want of a better explanation, are inclined to attribute many ills to their job. And, occasionally, they are exactly right. On the other hand, by closer questioning and careful examination, it may be found that the backache is sometimes due to a kidney stone or chronic prostate instead of heavy lifting; the dermatitis began with a wall cleaner used at home, instead of oil used at the plant; and the chronic gastritis may be aggravated by distilled corn rather than welding smoke.

Statistics, taken from the files of insurance companies and large corporations alike, show an alarming increase in "illness" during the Christmas holidays, beginning of the hunting season, the fishing season and at the time for summer vacations. Many such claims are not legitimate. They merely want someone else to pay for their holiday. Unless the practice is curbed by the efforts of the profession, it will raise the cost of sickness-accident insurance beyond the means of those who need it most, and place all insurance a step closer to governmental control.

The requests for letters from the family physician about change of job, leave of absence, report of illness, change of shift, or to cover absenteeism, place him in a very difficult position. Such requests constitute abuse of the doctor's goodwill by a small percentage of employes, who thereby take unfair advantage of the employer, the insurance company and their fellow citizens. They contrive to make him a party to a deceit that is for their own selfish interest. The doctor who has some familiarity with work in local industry is not easily fooled by such as these, and yet can add weight to his opinion for those that deserve it.

The average American workman deserves the close attention of the physician. He is a Very Important Individual!

The possibility exists that cancer often, or even usually, arises in man because of some change of chemical manufacturing activity by the body which results in an output of hormone-like chemicals or cell-growth regulators that stimulate or permit the survival of abnormal cells, rather than the normal group of hormones which maintain normal cell growth.

* * *

Whether it be merely co-incidental or not, there is some remote chemical similarity between the steroid hormones and constituents of tar which cause cancer in man and animals.

* * *

It is difficult to believe, in view of all the facts available, that there is not some very definite linkage between the occurrence of many common forms of cancer in man and abnormal functioning of the glands which produce the steroid hormones

* * *

Some seventy-five different substances which are classified as steroid hormones or related molecules, have been isolated from human urine.

Industrial Health Education in Michigan

By O. Tod Mallery, Jr., M.D.
Ann Arbor, Michigan

THE PRACTICE of Industrial Health and Occupational Medicine passed a significant milestone in April, 1955. On this date, the American Board of Preventive Medicine announced the requirements for physicians who wish certification in the specialty of occupational medicine. The principal purpose of a specialty board is to encourage and improve the practice of a specialty as well as to advance the cause and application of a special branch of medicine. In occupational medicine, the Board has set up the following requirements for new physicians going into the field.

1. Two academic years of graduate study in preventive and occupational medicine which shall follow the completion of an internship.
2. Not less than one additional year of supervised experience (residency) in occupational medicine in an industrial or medical organization.
3. An additional three years of experience beyond the years of training in the practice of occupational medicine.

In the early period of the operation of this Board, some special provisions may be in effect. Certainly, there will be accorded recognition to a "Founders Group" including the older and more prominent industrial physicians. Although it has not been finally established, this group may approach 30 per cent of the original applicants for certification. It is possible, but not yet fully determined, that additional industrial physicians who may not qualify for the charter group and who may not precisely meet the rigid Board requirements referred to, under some circumstances, may be accorded the privilege of taking the examination.

This final recognition on the part of a specialty board reflects many changes which have been taking place in the practice of occupational medicine over many years. Particularly rapid progress and growth of the specialty has taken place since World War II. Over the years, the medical practitioners engaged in industrial medicine have built up their own special body of knowledge. To this, they have added those particular skills developed by related fields of medicine, particularly preventive medicine, which have been focused on the special problems of health and occupation, environmental influences, and toxicology, as well as the science of engineering and industrial hygiene control. In addition to these technical and scientific developments, industry itself has turned increasingly to the medical profession for aid in the establishment and maintenance of industrial health departments. The increased demand for physicians capable of initiating and staffing such programs in industry has led the schools of medicine and of public health to provide training for physicians in this field.

Conferences and Clinics in Industrial Health

In the State of Michigan, the University of Michigan and Wayne University each provide a variety of courses, conferences and degree programs in industrial health. At Wayne, under the direction of Arthur J. Vorwald, M.D., Professor of the new Department of Industrial Medicine and Hygiene, bi-monthly conferences for physicians are to be inaugurated shortly. Specific occupational diseases will be examined, together with diagnosis, prevention and treatment, as well as influences of employment and environmental factors on non-occupational hazards. In addition, academic and in-plant programs are being organized for the teaching and training of students at the postgraduate level. These programs are designed to meet the requirements for certification by the American Board in Occupational Medicine and also to qualify the student for special degrees offered by the University.

The University of Michigan Institute of Industrial Health, the Medical School and the School of Public Health have been holding conferences and clinics in industrial health since 1951. These have been of two types. Some have been devoted to the intensive review of a single topic. For example, a conference on "noise" was designed to provide physicians and others in the health field with the current knowledge of occupational deafness, its causes, diagnosis and prevention. Other conferences have been designed to bring the physician particular knowledge of occupational medicine that

Dr. Mallery is Director, University of Michigan Institute of Industrial Health, Ann Arbor, Michigan.

has application to general practice. Examples of this latter type of conference include "Expert and Technical Medical Testimony in Medical and Health Cases" and a more recent meeting dealing with "Gerontology." These and other conferences are available for physicians in printed form.

Clinical presentations of occupational health problems have been included in the postgraduate programs offered by the University. These clinics have been conducted as part of the weekly course in Internal Medicine which runs throughout the academic year.

Intensive Programs of Study

One-year and two-year programs of study for physicians in Industrial Medicine and Occupational Health are offered at the University of Michigan. The one-year program offers qualified physicians two academic semesters of graduate study and an opportunity for in-plant industrial medical experience. After the completion of the graduate program, the degree Master of Public Health (Industrial Health) is offered through the School of Public Health. A similar nine months' program qualifies the candidate for the Master of Public Health degree.

A variation of this one-year program is available through a co-operative program with industry. This program combines eight months of experience in a designated industrial medical department and one semester, four months, of graduate study at the University. Credit towards the Master's degree is given for this program of graduate study.

The two-year program is a residency in industrial medicine offered at the Saginaw General Hospital integrated with experience in industrial medical departments in manufacturing and chemical companies. The residency has the approval of the American Medical Association and is the only one of its type presently in existence. In addition to the year of residency, two semesters are spent in graduate study at the University. The Master's degree is awarded after completion of the program.

Graduate Study in Prepartion for Specialty Certification

The American Board of Preventive Medicine requires two years of academic graduate study as part of the training required of the physician before the candidate may appear before the Board for examination and certification. During the past four years, some twenty physicians have been enrolled for graduate study in occupational health at the University of Michigan. Now, with the existence of the American Board, one can only speculate how many of this group might have stayed an additional period to advance themselves towards Board qualification. It seems likely that if sufficient interest is shown by physicians for extended graduate study that the medical schools and schools of public health within the State will offer programs to fit these individuals.

Training Offered to Undergraduate Medical Students

Both Wayne and Michigan have incorporated into the undergraduate medical curriculum courses, clinics and conferences to bring to the attention of their students the medical problems of occupation and the work environment. At the undergraduate level, it is not the intent to prepare a student for an intensive career in occupational medicine but rather to bring to his attention this particular field of practice and to integrate these special problems of occupation and environment into his over-all medical knowledge.

Summary

Conferences, seminars and short courses are available for physicians in practice who wish to brush up or extend their knowledge in the field of occupational medicine. For men who are looking at industrial health as a career, intensive programs of study are available, as well as graduate degrees in the field. For those who choose to devote their medical career to occupational medicine, preparation for certification in this specialty undoubtedly will be available in this state. The medical schools in Michigan significantly are bringing to their undergraduate students certain information and technical medical knowledge to assist the graduating physicians in meeting the changing patterns of medical practice. Occupational Medicine and Industrial Health are firmly established as part of the educational responsibility of the universities of Michigan.

Controlling Accident Tendency

By Harry B. Burr
Pittsburgh, Pennsylvania

HUMAN accidents express a relationship between human beings and their environment. In so doing, their frequency is subject to variation from individual to individual and from place to place. That such is the case has been confirmed again and again by both casual observation and systematic investigation.

Further confirmed is the fact that under current circumstances human accidents predominantly are attributable to personal rather than environmental causes. In fact, authoritative estimates of the proportion of accidents due to personal factors range as high as 80 to 90 per cent.[4]

An obvious implication of these findings is that the most important accident prevention techniques should be those which would deal effectively with personal accident factors. Unfortunately, such techniques have not yet been developed adequately. Whereas environmental accident elements are sufficiently tangible and distinct to be susceptible of control, personal accident sources are largely intangible. As might be expected under these circumstances, progress in environmental accident prevention has far outstripped that attained in controlling personal accident causation.

Safety programs dealing with environmental hazards have become intensive and, within their inherent limit, highly effective. However, with accidents so largely attributable to personal causes future progress in accident prevention necessarily depends largely upon finding effective means of controlling accident tendency.

Accident tendency may be construed as the inability of individuals to adjust to environmental circumstances. As such its co-determinants are individual adjustment ability and environmental adjustment requirements. Changes in either of these variables affect the relationship between them and so, the tendency to accident. Under these circumstances, it is not the absolute value of either factor alone which is of ultimate importance but rather the relation between the two.

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When it is said that up to 90 per cent of present accidents are attributable to personal factors, it is implied that under existing environmental conditions accidents would be reduced by this amount if individual adjustment ability and environmental circumstances could be so related that the former would at all times be equal to or greater than the latter. How widely this relationship between individuals and environments may be carried out depends upon a multitude of factors, many of which may be beyond control. However, the principle is such that in the degree to which this relationship is established accidents will be reduced.

Actually, the over-all relationship between personal adjustment ability and environmental circumstances is composed of two component relationships. These are: (1) the relationship between physical ability and environmental circumstances and (2) the relationship between psychological ability and environmental circumstances. Subsequent discussion considers the effect of inadequacies in each of these areas.

Physical Ability and Accidents

When bodily capacity is at best barely adequate to perform task requirements, two types of risk are introduced. First, the unit work act will claim physical capacity so fully that little or none remains for sudden adjustment. Second, cumulative effort may produce physical fatigue and result in a critically diminished ability to adjust to danger.

An example of the first type of risk is that of an individual of slight physique (or poor general health) performing a task requiring relatively heavy unit lifting. Under load, he literally may be weighed down to a point where, quite apart from his ability to apprehend danger, emergency accommodation movement is impossible. Similarly, individuals with specific handicaps who are engaged in tasks which maximize rather than minimize the effect of their handicaps are left without capacity to adjust to sudden environmental changes. An individual with impaired vision, who can drive a vehicle under ordinary circumstances, may react unfavorably in an emergency by reason of the visual defect which limits his perception of spatial relationships.

The second or fatigue type of risk is illustrated inherently by investigations which show that accident rates increase with abnormally long and/or intense work periods.[1] While this result may in part be due to a decline in mental alertness, it is

TABLE I. PHYSICAL EXAMINATION STANDARDS

	PQ	PQX	NPQ
CHEST (continued)		Bilateral pneumothorax without fluid (1). Three or more stage thoracoplasty (arrested) (1). Apparently arrested TB (1)*. Asthma (1). Pneumoconiosis (1). Extensive fibrosis or emphysema (1). Other conditions as classified by Diagnostic Division.	
HEART	Cardiorespiratory (functional) murmurs. Sinus arrhythmia.	Mitral systolic murmurs.	Active infections. Decompensating heart. Myocardial infarction within 3 months. Fibrillation (apical rate above 90).
		Cardiac hypertrophy from any cause (1). Enlarged aorta (1). Aortic murmurs (1). Congenital heart disease (1). Coronary disease (1). Myocardial infarction after 3 months (1). Fibrillation (apical rate below 90).	
ABDOMEN		Pregnancies up to 4 months (1).	Pregnancy after 4 months. Less than 2 months postpartum.
HERNIAE	Impulse only or enlarged rings.	Herniae without symptoms or complications. Herniae with symptoms or complications (1).	
G.U.		Hydrocele. Varicocele. Chronic venereal disease under adequate treatment. Sliding undescended testicle (1). Nephritis (1).	Active venereal disease. Active infections of GU tract including PID.
SPINE	Unlimited motion.	Scoliosis. Lordosis. Non-tuberculous kyphosis of moderate degree. Poker spine (1). TB of spine (1). Arthritis (1). Osteomyelitis (1). Low back pain (1). Slipped disc (1).	Any condition not suitable for light work.

*As defined in Appendix A.

almost certainly attributable in some degree to the reduction in speed and accuracy of muscular movement which accompanies physical fatigue.

In considering the physical factors bearing upon accident causation, the question of sensory-motor co-ordination may be raised. In this regard, it is necessary to distinguish between voluntary or conscious co-ordination and involuntary or reflex co-ordination. Of the two types, only reflex co-ordination is classed as a physical factor—voluntary co-ordination being considered in the psychological category. Experience suggests that only psychological or voluntary sensory-motor co-ordination is of primary concern in accident tendency. There is no evidence to show that sensory-motor co-ordination not involving higher nervous centers has any significant relationship to accident causation.

The over-all importance of personal physical factors in accident causation cannot be stated precisely since there has been little or no measurement of their separate effect in cases where both physical and psychological causes contribute to accident production. Nevertheless, experience indicates that physical deficiencies are of considerable importance in accident causation both directly and because they frequently give rise to psychological impairment.

The Chrysler Program.—Evidence suggesting the importance of minimizing the effect of physical disabilities in occupational placement is exhibited in Chrysler Corporation experience. In this organization employe injuries reported to the company's medical departments have declined over 25 per cent per exposure hour under the lowest rate achieved prior to the commencement of selective employe placement.[3] Enhancing this result is the fact that the company's injury visit frequency prior to commencement of the placement program was not unfavorable to that of comparable organizations.

By relating physical examination measurements to standards (Table I) which have been developed over many years, the Chrysler program classifies individuals according to their physical capacities into three groups. These groups are: PQ—physically qualified for any job; PQX—physically qualified for jobs not involving certain functions and/or certain degrees of function, and NPQ—not physically qualified for any work in mechanized industry.

The PQ and NPQ classifications are self-explanatory and in themselves provide safe bases for placement decision. For PQX or conditionally qualified personnel, however, individual descriptions of physical limitations are required to facilitate comparison of human capacities with job requirements. Only in those instances where human physical capacities clearly are sufficient to cover job requirements may placement be carried out with maximum safety.

Description of physical limitations in conditionally qualified personnel is accomplished by adding placement codings to the PQX rating. These codings are taken from a master placement code (Table II) which permits Chrysler physicians to translate medical diagnoses and findings into terms of work functions. In this way necessary information may be transmitted to placement

TABLE II. PQX-PLACEMENT CODE

GENERAL CLASSIFICATION

A. Heavy sustained labor. B. Moderately heavy labor. C. Light labor. D. Very light labor.

MODIFICATION

1. New hire (except service personnel) is NPQ. 2. Hernia statement advised

General Functions

10. No standing.
11. Standing less than 50% of the time.
12. Standing more than 50% but not all of the time.

20. No sitting.
21. Sitting less than 50% of the time.
22. Sitting more than 50% but not all of the time.

30. No walking.
31. Walking less than 50% of the time.
32. Walking more than 50% but not all of the time.

40. No climbing.
41. Climbing less than 50% of the time.
42. Climbing more than 50% but not all of the time.

50. No lifting or carrying.
51. Moderate or less than moderate lifting or carrying.
52. No pushing or pulling.
53. Moderate or less than moderate pushing or pulling.

60. No stooping.
61. Stooping less than 50% of the time.
62. Stooping more than 50% but not all of the time.

Special Senses

70. No near vision.
71. Some but not good near vision.
73. Some but not good distance vision.
74. No binocular vision.
75. Some but not good binocular vision.
76. No color perception.
77. Has vision in one eye only.

80. No hearing.
81. Some but not good hearing.

Specific Functions

90. No use of right hand or arm.
91. Partial use of right hand or arm.

100. No use of left hand or arm.
101. Partial use of left hand or arm.

110. No use of right foot or leg.
111. Partial use of right foot or leg.

120. No use of left foot or leg.
121. Partial use of left foot or leg.

130. Physical reactions not prompt.
135. No speech.

Environment

140. No danger from dizziness, fainting, or convulsions.
141. Nervous disorder (specify environmental limitations).

150. No exposure to dusts, smokes, fumes, vapors, gases and mists.
151. No exposure to excessive noise.
152. No exposure to excessive heat.
153. No exposure to excessive cold.

160. No exposure to any skin irritants (particularly no wet jobs.)
161. No exposure to specific skin irritants (specify).

170. Certain shift recommended (specify).

agencies while medical diagnoses and findings are retained as privileged communications in the Medical Department.

The master placement code from which individual codings are assigned is divided into five parts, each containing a series of limits. These parts are: (1) *General Classification,* which provides for assessment of relative effort capacity based on general health and physique; (2) *General Functions,* under which restrictions may be imposed on such activities as standing, sitting, walking, climbing, carrying, pushing and pulling; (3) *Special Senses,* in which visual and hearing limits are indicated; (4) *Specific Functions,* which deals with limitations in extremity performance, speech and physical reactions, and (5) *Environment,* which describes limits imposed by some diseases in terms of the places where individuals having those diseases may not safely work. Certain neurological, lung and skin diseases are the principal conditions requiring limitations described in this section.

During the past ten years, over half a million persons have been examined and classified under the Chrysler placement program. Approximately 40 per cent of this number have been individuals who were not physically qualified for every job and who, therefore, would have been rejected by older, more inflexible standards. Under selective placement, over 90 per cent of these persons have been classified as conditionally qualified and coded for physically safe job placement. Thus, selective placement has made more people available for regular employment under safer conditions than was ever before possible.

It should not be construed from this discussion that proper relating of physical factors and task requirements solves the largest part of the accident tendency problem. Important as it is, the scope of such control relatively is limited. Experience regularly shows that accident susceptibility is influenced only partly by efforts which deal with physical factors alone and so additional corrective action is needed.

Psychological Accident Factors

That accident tendency is influenced only partly in the majority of cases by efforts which deal with physical factors alone suggests the importance of psychological elements. Despite their intangible nature, the effect of mental processes upon the ability of individuals to adjust to environmental circumstances is both extensive and profound.

Psychological shortcomings in accident tendency are associated with inability to apprehend successfully the interrelationship of presented facts. In relation to a given environmental situation, mental integrative potential may be insufficient to provide adjustment or be so disorganized as to be inadequate.

Inadequate Integrative Potential.—Certain causes of insufficient integrative capacity are indicated by some of its components. To a large extent, integrative function depends upon the heredity and health of central nervous structures and upon memory. Thus, hereditary limitations may restrict integrative performance. Organic disease and physiologic factors affecting central nervous structures necessarily influence mental processes and may result in insufficient integrative capacity. Memory provides an important means whereby past experience may facilitate the formulation of current adjustment patterns. Conversely, lack of experience and/or memory defects restrict integrative capacity.

The effect of physiologic factors upon the central nervous system and mental acuity is an important object of current research. As elsewhere, the vitality of central nervous tissue is supported by energy derived from the combustion of oxygen and nutrients and by the removal of waste products resulting therefrom. Accordingly, any factor affecting this supply and/or waste removal may influence central nervous and mental performance. Thus, circulatory and/or hemic impairments may limit transport of these elements so as to substantially reduce mental acuity. By the same token, metabolic factors may cause substantial reductions in nutrient supply and result in decreased mental performance.

To illustrate, in some persons dietary ingestion of sugar or sugar-yielding foods so stimulates insulin secretion as to result in a substantial reduction in blood sugar (glucose). In turn, this reduction deprives central nervous tissue of nutrition which reduces its vitality and thereby lowers mental efficiency. Although not yet certain, the "letdown" occurring at such times may be related to accidents.

The importance of remembered experience to mental integrative capacity is that past decisions and conclusions may be applied to facilitate adjustment to current circumstances. To a large extent, such applications take the form of guides in developing behavior patterns which tend to minimize risk. Both the "rashness of youth" and the "caution of age" may be explained on the basis of remembered experience and are exemplified in the frequently observed decline in accident rate with age.[2,6] Too, memory carries the record of personal performance ability and so provides a guide for current behavior. Thus, a physically handicapped person may be more cautious and hence equally as safe as an able-bodied person.

It is difficult to estimate the importance of inadequate integrative potential in accident causation. As yet, there has been insufficient investigation of the relationship between integrative potential and accidents to furnish a basis for firm conclusion. Nevertheless, lack of integrative potential would seem to explain the behavior characteristic known as "clumsiness" and this is ubiquitous.

Disorganization of Integrative Capacity.—It is intuitively true that in the degree to which an individual's integrative capacity is disorganized, it is unavailable for his adjustment to environmental circumstances. Inquiry is thus directed to two major factors which disorganize psychological effort.

In this regard, the special disability of psychoneurotic individuals to work under pressure and distraction is to be noted. It has long been established that persons with psychoneurotic conflicts perform significantly poorer on tests involving sustained attention and directed mental effort than do normal individuals. In such tests, the psychoneurotic's inferiority is evident both in terms of accuracy and, to an even greater degree, in time required to complete tasks.[7] This latter factor is of particular importance in reference to a subject where "quickness" may mean the difference between safety and injury or even survival.

It appears inevitable that any mental conflict, by restricting integrative performance, tends to increase accident tendency. Thus, in addition to the long-standing conflicts of some persons, short-term conflicts which intermittently "infest" the lives of most individuals may be expected to increase accident tendency. This complicates the problem of control, but must be allowed for in any full-scale solution of the problem.

A second factor leading to disorganization of psychological effort is described in the important and relatively recent research of Keenan, Kerr and Sherman among workers at the International Har-

vester Tractor Plant.[5] A principal observation in this investigation was that workers with low "physical frustration tolerance" under adverse environmental conditions probably have somewhat higher accident frequency than their co-workers. "An accumulation of physical frustration tensions leads easily to 'distractive' behavior which often results simultaneously in reduced quality of work and accident." From this, the authors concluded that "major preventative effort can most profitably be expended in working to alleviate as much as possible the over-all physical frustrations which impinge on personnel."

Commentary.—From the preceding discussion, it is apparent that both the possibility of correcting psychogenic causes of accident tendency and the nature of treatment for such causes can be surely established only when specific sources are defined. For example, where accident tendency results from an uncorrectable lack of integrative potential the alternatives are: (1) to restrict individuals to environments requiring lesser integrative performance or (2) to reduce the integrative requirements of their environments. On the other hand, if inadequate integrative performance is due to curable organic disease or to mental conflict, the final objective should be the elimination of these disabilities. This latter action not only reduces accident tendency but improves capability generally.

There is no question of the ultimate importance of specific diagnosis and treatment. However, current application of such measures must be weighed against the practical limitations which they now face. Present psychoanalytic techniques require highly specialized personnel, relatively long periods of time and relatively great financial charges. In addition, it is doubtful if they could be applied effectively against the great problem presented by short-term mental conflicts. All factors considered, it would appear that the limitations are such as to preclude widespread utilization of psychoanalytic techniques at this time.

It may also be observed that treatment measures calling for reduction in the integrative requirements of environments can, in general, be relied upon only in the long run. Costs involved in altering and/or replacing present buildings, equipment and processes are such as to provide a substantial restriction on such treatment.

Finally, it must be remembered that accident tendency involves the *relationship* between environmental adjustment requirements and human adjustment capability so that improvements in either factor alone do not guarantee a solution. Unless capability is equal to requirements, the problem still exists. While attempting to improve both of these factors, the primary need is to insure that in each individual case they are related properly.

Conclusion

Accident tendency occurs when human adjustment ability is inferior to environmental adjustment requirements. It is thus the product of two variables rather than the independent effect of either. From this it follows that the only certain solution lies in *controlling the relationship* between these factors in such a way that adjustment capacity is always equal to or greater than environmental requirements.

Independent improvements in the physical and mental factors governing individual adjustment ability and/or reductions in environmental requirements will simplify the problem and in some instances may eliminate it. However, such actions cannot assure regularly that adjustment capability will be equal to environmental demands when the two factors are brought together. Again, then, the only certain solution lies in controlling the relationship between these elements.

Since the relationship between individuals and their environments involves both physical and mental factors, control measures may consist best in two parts. On the physical side, control requires that each individual's ability provide a margin for emergency adjustment over and above his routine environmental requirements. A practical method for establishing this control exists in selective physical placement procedures such as those in the previously described Chrysler program.

On the mental side, control requires that individual integrative performance be adequate to environmental demands. In turn, this requires that the integrative needs of environments be established, that the integrative performance level of individuals be determined and that these two components be related regularly.

As yet, there is no well-established method for carrying out the latter type of control. Nevertheless, the elements necessary for projecting a means of control appear to be present.

When the necessary relationship between in-

dividual physical ability and environmental physical requirements has been established—as in selective physical placement—subsequent accident experience may be ascribed more surely to psychological factors. Under such circumstances, the number of accidents per capita occurring in each environment may be used to measure the need for integrative performance in those environments. At the same time, accident tendency may be attributed more surely to inadequate integrative performance.

Now, if individual and environmental accident records be maintained, a means is present for identifying those who are psychologically prone to accidents and for relocating them in environments requiring lesser integrative performance. In other words, there is a basis for restricting psychologically unsafe persons to psychologically safer areas.

It is not claimed that this method alone provides the degree of control which ultimately is to be desired. In dealing with the results of psychological insufficiency rather than its causes, there is still the necessity for suffering the adverse effects of experience before correction can be made. Nevertheless, this method does permit those adverse effects to be mitigated, and this is a desideratum.

Ideally, this method should exist as a safeguard secondary to control measures utilized prior to exposure. There is no full substitute for a practical preplacement program which would determine individual integrative status and properly relate it to environmental needs.

In this regard, one approach may be that of testing adjustment capability by the rapidity with which accurate motor response follows sensory stimulation—as for example, in exercises of hand-eye co-ordination. Performance on such tests gives no clue as to causes which may deter the process of perception and response but does indicate the fact of deterrence. The well-known work of British investigators[1] indicates that such testing, to some extent, will measure individual accident tendency in skilled occupational groups but as yet is unable to measure accurately the tendency among unskilled groups. Possibly, improvements can be made by increasing the sensitivity of this type of testing.

In any event, there is one consideration which should always be present. Both personal adjustment ability and environmental circumstances are fluctuant in each case rather than constant. In relating these factors, all possible allowance should be made that an individual's basic ability—in contrast to his best ability—will be adequate to the most severe demands which may be imposed upon him.

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It is never too late to treat a cancer at least locally.

* * *

More cancer patients than ever before are willing to undergo surgery; this raises the odds in favor of cure.

* * *

In breast cancer, attention should be directed to the entire mammary system; since eight per cent of the patients who survive the first mastectomy develop cancer of the other breast.

* * *

In all diagnosis and treatment of cancer, the time element is still the most important factor if cure is to be obtained.

* * *

The most important symptoms of primary cancer of the liver are right upper quadrant pain, anorexia, and weight loss accompanied by ascitis, jaundice, and hepatomegaly.

There is no distinction between diagnosis and detection of cancer; both are procedures for identification of the disease when present in the patient being examined. They are not some mechanical or technical process that can safely be relegated to lay persons.

* * *

Unless and until a far greater percentage of the population learns some of the simple basic facts about cancer, the amount of money spent on service to the cancer patient, will increase instead of decrease as it should with increasing emphasis on cancer education which is the cornerstone of cancer control.

* * *

Decision by a layman as to whether he has or ever had cancer and whether he had been cured is "entitled to little if any weight."

* * *

Wilms' tumor is now treated by immediate transperitoneal nephrectomy and postoperative radiation.

How the Physician Can Obtain Help from the Industrial Hygienist

By Frank A. Patty
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SINCE the general practitioner is doing about 85 per cent of the industrial medical work in the State of Michigan, it should be of considerable interest to him to know how the industrial hygienist can help him do his job easier and, in some instances, better. Whether the physician serves as a part-time plant doctor employed by management or as the family doctor for his working patient, his diagnostic and health maintenance problems for employed men and women are essentially the same.

The physician who is concerned with the health of the employes of only one industrial plant has a much simpler job than the private practitioner who may be concerned with a cross section of the working force of a large community. In this case, many of his working patients may come from small industries that have little or no health maintenance supervision.

Although it was nearly 250 years ago that Ramazzini pointed out the necessity for the physician to inquire into the occupation of the patient, it is still good advice, as far as its goes.

When the possibility of an occupational illness presents itself, the first source of information to be exhausted is, of course, the patient, determining exactly what he does and with what materials he works. His opinion of their harmfulness, though of interest, is frequently grossly erroneous and often colored by personal reasons such as, for instance, a desire for transfer to a more attractive job. It is well to ask him why, if he thinks he is exposed to an injurious environment, and how he thinks it should be corrected.

Up until we were well into the twentieth century, unhealthful conditions were believed to be inherent in certain trades. During the last few decades, however, these trades have been studied to detect and evaluate their harmful exposures, and much engineering skill has been brought to bear upon methods of controlling or preventing exposure to toxic materials. It is no longer sufficient to inquire into a man's occupation, but it is also necessary to know all of the questionable materials or conditions to which he is, or may be, exposed. Not only must the physician know what these conditions are, but he also must know the quantity or intensity of any exposure and what the probable human reactions to this environment are. This information is essential to the physician in order that he may, first, correctly diagnose the illness and, second, remove the cause of illness so that his patient can get well. Obviously, if the man has not been exposed to harmful materials, his ailment did not result from his working environment, but if there was a known or possible injurious exposure, then further investigation to establish the specific cause of illness can be made. This is the industrial hygienist's territory, and here he can be of immense help to the diagnostician.

As an example of how this works in practice, suppose we consider lead—the oldest recorded cause of an occupational disease, but widely and, for the most part, safely used today. Many men who regularly work with lead or its compounds are never exposed to harmful amounts, while others with incidental contact may have a serious exposure. Essentially, all industrial lead poisonings except some of the cases concerned with tetraethyl lead, result from inhalation of lead or its compounds rather than from ingestion or skin absorption.

The patient may come to his physician rather obviously ill, but with none of his symptoms specific. It may develop that he is a metal finisher in a plant where he uses power tools to grind, sand, and buff steel having lead-soldered joints. The possibility of a lead exposure is established because the man is working with lead. A diagnosis of lead intoxication based on those two facts alone would require either unusual skill or temerity, but by enlisting the aid of the industrial hygienist, additional factual evidence can be obtained that will facilitate the decision of whether the illness is related to exposure to lead. The job should be observed before an attempt is made to evaluate the exposure. The observation should establish whether leaded surfaces are ground, sanded, or buffed sufficiently to present the possibility of inhaling lead dust. The possibility of ingestion of significant lead in an operation of this nature would be remote, indeed. If the operation is judged to involve a possible inhalation exposure,

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three courses are open for establishing whether the exposure is significant.

1. Air samples taken in the breathing zone where the patient worked may be collected and analyzed for lead. If the lead content is found to average more than 1.5 milligrams lead per 10 cubic meters (353 cubic feet) of air for an eight-hour day, or correspondingly less for longer work periods, an excessive exposure has been established.

2. Where air samples, for one reason or another, are judged to be not representative, as for instance where the exposure varies widely, nor a sufficiently reliable index of exposure, urine specimens may be collected and analyzed for lead. Several spot samples or at least one twenty-four-hour sample are necessary to be significant. When repeated results are less than 0.2 milligram lead per liter of urine, cause and effect relationship for men working up to near the time of sampling may be excluded. They may be assumed to exist when the results are 0.2 and above.

3. The most reliable diagnostic aid, however (as well as the best index of exposure to any form of lead except tetraethyl lead), is arrived at by analysis of a sample of the patient's blood to determine its lead content. A verified result of .08 or less milligram lead per 100 grams of whole blood casts serious doubt of causal relationship between a workman's non-specific symptoms and the work he has performed in the preceding day or days. A verified result of .09 and above indicates excessive exposure and may be assumed to establish cause and effect relationship.

These analyses require the services of a competent analytical chemist, and the collection of suitable samples must be under the direct guidance of persons familiar with the working conditions, whose understanding of the physiological and technical background of sampling procedures is complete. The amounts of lead involved are tremendously small, and any uncontrolled sources of a trace of lead contamination render the results useless.

No single unverified result carries a large amount of significance until confirmed by an additional test. Results indicating excessive exposures (air, urine or blood leads, even in the ranges somewhat above the figures stated) indicate neither illness nor impending illness, but are only indications of exposure and of absorption.

The lead storage-battery industry may be cited as an industry that necessitates continuous industrial hygiene service. However, where good mechanization, enclosed processes, and well-designed process ventilation are provided, atmospheric lead concentrations can be held down to acceptable levels in all but a few operations in this industry. In these few circumstances, the workmen still have to be provided with respirators. Employment in the modern battery plant cannot be assumed to involve exposure to significant amounts of lead.

Painting is another occupation in which it used to be assumed that excessive lead exposures were the rule rather than—as at present—the exception. There was a time when any painter who developed cramps was likely to be diagnosed as having painter's colic or plumbism. Nowadays, there is relatively little lead used in paints except in house paints, and painting as an occupation in factories no longer carries any implication of harmful lead exposure unless supported by analytical data of lead in the atmosphere or in the biological fluids of the exposed workman. If a painter is found to have plumbism, it is frequently necessary to inquire into his outside activities in order to trace the source of his exposure, which may prove to be house painting or the more hazardous job of removing old paint in preparation for a paint job.

An interesting case of lead absorption was brought to light recently in a factory by a routine blood-lead check-up of all employes having a potential exposure to lead. This man was engaged in applying solder as a filler over welded seams, and he had visited the medical department with non-specific complaints of gastrointestinal disturbances. Atmospheric tests indicated that the environment was safe, no excessive lead exposure, but an analysis of the blood of this man revealed an unusually high lead content. Since the work exposure was believed to be within accepted hygienic practice, inquiry was made into his outside activities and it was found that he was repairing automobile fenders at home by filling dents with lead solder, smoothing it off with a grinding disc, and inhaling lead dust during the process.

Another classic example of an occupational disease is silicosis, and here again the co-operation of the industrial hygienist is essential for complete diagnosis. The employe's history and some symp-

toms may suggest that he is a silicotic and this may even be supported by the characteristic nodular type x-ray photograph of the lungs, but unless it can be established that the workman has been exposed for a sufficient period of time to the inhalation of dust containing a significant amount of silicon dioxide, positive diagnosis is difficult to establish. In this instance, the industrial hygienist would collect and count under a microscope the dust particles from a measured quantity of air. Where doubt existed about the nature of the dust or where the silicon dioxide content of the dust is very significant, he would need to collect sufficient air-borne dust to analyze for its silicon dioxide content. The dust concentrations, silica content and exposure time for all work stations would need to be weighed in establishing the extent of the individual's exposure. Also the man's exposure to other contaminants (as, for instance, iron fume) that are known to cause a non-disabling lung condition exhibiting a nodular type of chest x-ray resembling that of the silicotic, could be important.

It is rather obvious that where the patient is a foundry employe, with an x-ray of the chest that shows nodulation, without the typical symptoms of silicosis, factual information regarding the environment is most desirable. The same would apply to the porcelain enameling industry and glass manufacture where dusts of widely varying silicon dioxide content are encountered. Some of the raw materials used in making glass and enamel contain significant amounts of free silica, and in the grinding or handling of these materials, such as feldspar and sand, there may be opportunity for excessive exposure to silicon dioxide dust, unless the ventilation is well engineered. When the raw materials are fused together to form a frit or glass, however, the silicon dioxide combines chemically to form silicates, and the free silica remaining, if any, is never in significant amounts. It is not possible to develop silicosis from exposure to dust or mist from the grinding or polishing of glass, unless sand is used as the abrasive. Likewise, the grinding or spraying of enameling frit in the process of making porcelain enamel does not present an exposure that can cause silicosis.

Solvents are another class of materials that present inhalation exposures in industry, where they are used for various purposes such as metal cleaning and for thinning paints and lacquers. These materials are nearly all fat solvents and, as such, they defat the skin upon contact, but absorption through the skin is usually not a matter for serious concern. The fast-drying solvents, by their very nature, evaporate into the air to be inhaled and absorbed unless they are controlled by ventilation. Most industrial solvents are either low in volatility or are of moderate toxicity; petroleum solvents such as mineral spirits or Stoddard's solvent are widely used. Occasionally, or possibly I should say too frequently, however, volatile and toxic solvents are carelessly used. These include benzol, carbon tetrachloride, tetrachloroethane, methanol and others.

Carbon tetrachloride is a very popular but dangerous solvent. It is popular for several reasons. It dissolves oil and grease readily and dries quickly, which makes it useful as a spot remover. Its odor is not offensive and is even considered pleasant by some persons. It presents no fire and explosion hazard, since it is nonflammable. It is, however, toxic, and prolonged inhalation of relatively low concentrations can cause serious poisoning. It deserves respect both in the plant and at home. The amount of exposure of the individual is usually best determined by relating the breathing-zone concentration to time. In some instances, however, the amount of the solvent or its metabolic products found in biological specimens from the workman are a more reliable index of an individual's exposure.

There are a few industrial chemicals known as aromatic nitro and amino compounds, however, that are very hazardous upon contact with the skin. Two rather common ones are nitrobenzene and aniline. These materials can cause serious poisoning from skin contact with soiled clothing, gloves, or shoes. Phenol is another common chemical encountered in and out of industry that is dangerous when in contact with the skin in significant amounts.

Other environmental contaminants or problems include x-rays, alpha and gamma rays, radioactive isotopes, heat, illumination, noise and others that for want of space cannot be detailed here. In all of these instances, the industrial hygienist can offer valuable assistance to the physician.

So much for recognizing and measuring the degree of exposure. If the patient is to respond properly to treatment, the most important thing is to terminate the exposure, and here is another way in which the engineering skill of the industrial hygienist can be most helpful. There are many

ways of controlling an exposure: for instance, substitution, isolation, changes in the operation, ventilation, et cetera. The engineers in the plant where the patient works may not properly understand the situation nor be in a position to provide satisfactory and prompt control, but the industrial hygienist by working with the plant people can usually develop a prompt and mutually satisfactory solution of the problem. The physician, in this way, can make certain that any exposure the patient may have had is terminated during the period he is undergoing observation or treatment.

By co-ordinated effort, the physician and industrial hygienist, under favorable circumstances, can relate plant air contamination to the health of groups of workmen. When medical findings, whether positive or negative, are combined with industrial hygiene information, such as the nature and amount of air contamination to which an individual or group has been exposed for months or years, valuable data for future guidance have been accumulated. In this manner, also, tentative air contamination bench marks or hygienic standards are either supported or refuted and corrected.

We see, then, five ways in which industrial hygiene aids the physician:

1. Recognizing harmful work exposures.
2. Evaluating the exposures.
3. Providing information the physician can use as a diagnostic aid.
4. Controlling the exposures.
5. Providing information regarding safe practice standards.

A brief discussion of where and how to obtain the assistance of industrial hygiene people is in order. The larger industrial plants may have an industrial hygienist in the plant or available on call. The State Health Department at Lansing has a well-staffed group with regional offices throughout the state. The Detroit Health Department has its own Bureau of Industrial Hygiene available for duty within the city. Some insurance companies provide industrial hygiene service to their assureds upon request. There are several private consultants in the field, and some of them carry announcements in the quarterly publication of the American Industrial Hygiene Association. The officers of this Association or of its Michigan section will provide the names of local consultants.

Some physicians may wish to obtain firsthand information from a personal visit to the plant and the work station. This can usually be arranged through the plant physician, the nurse, safety engineer, personnel director or other representative of plant management. It is very important that the physician in general practice keep abreast of developments in the field of industrial hygiene and toxicology, because many new chemicals and many new processes are currently introducing new harmful exposures. The designation of non-occupational diseases as occupational and the failure to recognize occupational diseases are both too common. If offhand misdiagnosis of occupational disease is to be avoided, it becomes necessary to inquire not only into the patient's occupation, but more especially into the factual data regarding possibly harmful work exposures.

It appears appropriate to close by paraphrasing Dr. Robert A. Kehoe. Human nature being as it is, there is an inevitable tendency for the workman, members of his family, his legal advisers and, yes, sometimes even his sympathetic family physician, to attribute any obscure illness to the effects of the man's working environment. Therefore, the physician finds it necessary to put forth his every effort in the light of current medical knowledge to confirm or exclude the patient's work as an etiologic or contributing factor in the illness of an industrial employe.

The administration of testosterone propionate as a therapeutic agent for any condition is inadvisable in men over fifty years of age, as it might activate a quiescent prostatic cancer.

* * *

In spite of encouraging results obtained with chemical agents, radiation therapy still remains the treatment of choice in most of the lymphoblastomas and chronic leukemias.

* * *

Most cancerphobiacs do not have cancer.

The cancerphobiac is a psychiatrically ill person, a person suffering a fear, the cause of which resides in his unhappy past experience with certain significant people. Such patients differ symptomatically very little from the excessive hand washers, the germ fearers, the syphilophobiacs and even the all-too-frequent hypochondriacs.

* * *

Cancerphobia is merely a symptom, a symptom of an anxiety-ridden person who has latched his otherwise vague fears onto cancer.

From Carpet Tacks to Cargo Ships

A Program for the Prevention of Occupational Diseases

By Albert E. Heustis, M.D., and
John C. Soet
Lansing, Michigan

WE have a rule in occupational health that any industrial operation can be performed, providing we know the hazards associated with it and set up a system to control them. As a public health agency, our major interest and objective is the prevention of occupational diseases through such control systems.

It should be pointed out at the outset, that occupational disease is not confined to the obviously hazardous industries. Experience has shown that no industrial process exists which is absolutely immune from occupational disease. The wide variety of processes and materials used in manufacturing and the individual susceptibility of every worker make every operation significant.

To illustrate the point, consider the materials and processes which go into the production of a few common articles in general use:

A Desk, finished with lacquer, which contains amyl acetate and butyl acetate and can cause headache and vertigo, oppression in the chest, nausea, coughing, and irritation of the mucous membranes of the eyes, nose and throat;

A Telephone, whose outer casing is made of synthetic formaldehyde resins—a severe skin irritant;

Windowglass, high in silica content, causing silicosis and radiant heat burns;

Asphalt Tile made from stripping in the petroleum industry, a carcinogenic material;

Cloth produced on looms which produce a noise of high intensity and frequency, causing loss of hearing in certain ranges;

Buttons made from melamine formaldehyde which is highly irritating to the skin.

These are just a few of the more common manufacturing processes and materials which involve the possibility of serious occupational disease. They illustrate another significant point. The control problem is not solved by elimination. If we eliminated all hazardous operations, there would be no industrial progress—in fact, no industry. Occupational disease prevention is a matter of controlling operations to the point where they are kept below hazardous levels.

The Michigan Department of Health has now completed twenty years of experience in carrying on an occupational health program. During that time, responsible management has become interested in sound health measures. But, in practice, there is still often a long rough road between the acceptance of a principle and the action necessary to carry it out.

An example will illustrate our method of approach.

A few months ago, a routine investigation was made by our field staff in a manufacturing plant employing about 1700 workers. It was found that the plant had just begun operations on a new contract involving the leading of metal panels. Some 500 workers were assigned to the new project.

In leading operations, preventive measures are an integral part of the production process. From their method of operation, it appeared that the plant had no previous experience in this type of production and no concept of the potential hazard involved. In our first conference with the management, we were told they had not anticipated the financial outlay necessary to install and institute engineering and medical control procedures, and they expressed grave doubts as to their necessity.

Three weeks and several meetings later, we had made little progress. We did arrange, however, to obtain urine specimens on about 120 workers directly exposed to lead and dust fume. Analysis of these specimens revealed high lead absorption among 65 per cent of the workers. A lead poisoning outbreak was a certainty in from four to six weeks. Quick action was essential.

From its establishment in 1873, Michigan's state health agency has been authorized to determine the effects of employment upon health. As early as 1874, a Governor's Special Study Commission recommended that a separate division be set up in the State Board of Health to promote better health conditions in the mines, mills and factories, thus antedating by sixty-two years the actual formation of the Division of Occupational Health in the Michigan Department of Health. In 1912, Michigan passed a law requiring compensation for industrial injuries, and in 1943, all occupational diseases were included. The reporting of occupational diseases was required in 1937, and the Department was authorized to take appropriate measures to prevent them.

Dr. Heustis is Commissioner, and Mr. Soet, Director of the Division of Occupational Health, in the Michigan Department of Health.

All the authority of the Michigan Department of Health was placed behind our demands for installation of controls within a twenty-day period. The prospect of shutting down production and the possibility of future high compensation costs brought immediate results. Within fifteen days, most of the engineering controls were installed and the management retained a physician and employed two nurses. We had averted a situation with serious potentialities, both for the workers and management.

It is the function of the Division of Occupational Health to deal with occupational hazards and to do so in time to prevent occupational diseases. Generally speaking, we have been able to accomplish this by working hand in hand with management to assist a plant in overcoming its difficulty.

Pneumoconiosis

A significant occupational health problem in Michigan is the prevention and control of pneumoconiosis and more specifically, silicosis. Silicosis is traditionally associated with the foundry industry, and Michigan's iron and steel foundries are an important and basic part of the state's economy with more than 50,000 workers employed.

In recent years, improvements have been made in equipment and procedures which have done much to reduce the incidence of silicosis in foundries: steel shot to replace sand as an abrasive material; positive pressure air helmets; improved methods of ventilation; and substitutes for silica in parting sand. These are but a few of the effective innovations. In large production foundries, automation is being rapidly introduced which will eliminate the silicosis potential on many individual operations. Unfortunately, most of these improvements apply only to large production foundries. The methods of operation in many of the small hand and floor molding foundries still leave much to be desired.

The pneumoconiosis potential is by no means confined to the foundry industry. We have hundreds of industries where toxic dust exposures exist. Mining and quarrying are in this classification. The Occupational Health Division's Upper Peninsula office works closely with the mining industry, not only in the control of silicosis, but in other problems of occupational health significance.

Of special interest in the mining field is a new copper mining development project at White Pine, Michigan, the largest project of this kind in the United States. In the past three years, the mining company has sunk shafts, built mills and smelters as well as a complete and modern town site. The copper is extracted from a low-grade chalcocite ore containing about 26 per cent silica. Since early development stages, we have worked with the company on all operations of health significance. After a study of Canadian experience, a large-scale aluminum therapy procedure has been installed. It is the first major installation of this type in the state and it should give a first-hand opportunity to determine the effectiveness of this procedure in combating the silicosis problem in mining operations.

In practically all cases of dust-producing industrial operations, the installation of proper engineering control procedures is an effective measure in maintaining dust-free air and thus reducing the incidence of pneumoconiosis.

Dermatitis

Diseases of the skin constitute one of the most frequent and persistently annoying occupational diseases and are responsible for a high percentage of compensation claims. While individual allergy may be an important factor, certain operations and materials are responsible for the major number of occupational skin diseases. Briefly, these are: cutting and drawing oils used in machine shops and metal stamping plants; chemicals used in the plating industry; natural and synthetic solvents used in metal cleaning; synthetic adhesives and glues; as well as a whole series of oxidants and reducing agents.

The whole occupational dermatitis situation is aggravated by the progressive introduction of new types of plastics and resins, especially when these resins have specific properties which can be used to advantage. Recently, a new group known as epoxy resins has appeared in many industrial operations and processes. These epoxy resins have high adhesive strength, and are self-polymerizing. When used with polyester resins in fiber glass, the resulting material is high in tensile strength and can be used in making tools and dies and as a substitute for wood patterns. These same materials are used in making plastic automobile bodies.

When this epoxy group first appeared, it caused many persistent cases of dermatitis. As we accumulated experience in handling the material, protective measures were developed to reduce the incidence considerably.

Radiation

Radiation exposures in industry from x-ray machines, radioactive isotopes, or from natural sources have increased markedly in recent years. The largest increase is in the use of x-ray machines. Most large metal-working industries are equipped with large x-ray machines, radium, or radioactive cobalt. Two of the largest x-ray machines in the world—15 million volt betatrons—are located in Michigan. The carcinogenic properties of ionizing radiation make it imperative that these installations be monitored on a frequent and regular schedule. A section in the Division of Occupational Health supervises the work in this expanding field. In addition to monitoring, we are actively engaged in setting up specifications for proper shielding of x-ray installations in hospitals and clinics as well as in industry.

We also work closely with the Atomic Energy Commission on licensing radioactive isotope users in the state. The Atomic Energy Commission forwards the lists of radioactive users in the state to the Michigan Department of Health, and these installations are monitored on a routine basis. At the present time, we are working on two large installations—one a radioactive research laboratory and the other a planned nuclear power reactor plant.

In the immediate future, we expect to see an accelerated use of radioactive isotopes and a number of states are now considering legislation to protect those working with the radioactive materials as well as those living in the immediate area. The use of radioactive isotopes on a large scale also brings up pertinent problems in pollution of lakes and streams.

Lead Poisoning

The toxic effects of lead have been known for centuries, and plumbism is one of the earliest recorded occupational diseases. In spite of its toxicity, the unique chemical and physical properties of lead make it a valuable metal for a wide variety of industrial and commercial applications. Automobile bodies, batteries, bearings, brass and bronze castings, production soldering and the printing industry account for extensive uses of lead in Michigan. The advent of the sedan type body in the 1930's resulted in one of the most serious lead poisoning outbreaks of modern times. As a result of this experience, extensive research developed effective engineering and medical control procedures. Lead workers in automotive plants are under constant medical supervision. Atmospheric lead, blood, urine and porphyrin tests are routine procedures. The worker is immediately transferred and immediate study is made whenever any of these tests show an increase or abnormal lead absorption.

These same tests are used by the Division of Occupational Health to determine the need or effectiveness of engineering controls in all plants using lead. The analysis of lead in blood and urine requires skilled and exacting techniques, as well as specialized laboratory equipment. With hundreds of employes working with lead, the large automotive plant can maintain technicians and special laboratories, but this is impractical or impossible for the smaller plant.

To further our objectives in the control of lead hazards, the Division of Occupational Health maintains a biochemical lead analysis laboratory service. This service is available to the physician who suspects lead poisoning in an individual patient or to the plant physician with a few lead workers under his supervision. Micro amounts of lead are involved in the analysis and the slightest contamination in the specimen will give high and misleading results. It is therefore necessary to use special lead-free containers and lead-free needles and syringes. These are supplied on loan by the Division of Occupational Health to the physician on request. In cases where frequent routine examination is indicated, arrangements should be made with private laboratories equipped to run lead determinations on body fluids.

Solvents

The cleaning of metal surfaces preparatory to painting or plating is an extensive and important part of metal working operations. Acids, alkalies and synthetic solvents are used for this purpose. While the acids and some alkalies are of interest to us, our first concern is in the synthetic solvents used for cleaning and degreasing. The three solvents commonly used are carbon tetrachloride, perchlorethylene and trichlorethylene.

Carbon tetrachloride, of course, is the most toxic of the three solvents and its use is limited to a few specialized cleaning operations and, infrequently, by industries who are not aware of its toxicity. Machines have been designed which will reduce the synthetic solvent hazard to a minimum when they are properly operated and maintained. Often, however, the machines are overloaded and

poorly operated, resulting in a high solvent vapor concentration. This toxic condition can be aggravated when degreasing operations are located in the same area with welding operations. The heat from the welding flames breaks down the chlorinated solvent into phosgene and water.

This situation has occurred in three plants in the past month, causing severe illness among the workers in the area. It is most likely to occur during the winter months when air circulation is confined within the plant. We attempt to keep welding operations completly segregated from degreasing operations, but in some instances we have found air currents carrying chlorinated solvent vapors underneath doors to points 100 feet away from the degreasing operations.

While carbon tetrachloride is used to a limited extent in industry, it is unfortunately used to a great extent in commercial applications, such as home dry cleaning, and in fire extinguishers. Several deaths occur each year as the result of the home use of carbon tetrachloride. In conjunction with our educational efforts on the use of chlorinated solvents in industry, we have been actively engaged in making the general public aware of its dangers.

The Division of Occupational Health has prepared a list of substitutes that can be used in place of carbon tetrachloride. This list gives the name of the solvent, the composition, the flammability and the recommended specific use and is available for general distribution.

Noise

Industrial noise is a critical problem facing industry today. For years, loss of hearing was considered a part of the normal risk involved in working in industry. As a result of recent court decisions in some states allowing claims for industrial hearing loss without disability, the problem has become one of serious concern to management. There are numerous industries in our state having noise levels sufficiently high to produce permanent hearing loss. We have experienced a progressive increase in the number of requests for assistance in the evaluation of noise potential in the past two years.

Two projects recently completed by the Division of Occupational Health may provide some interesting data on hearing loss at specific frequency and intensity levels. In addition to our sound level studies, the medical department of both plants made audiometric examinations on all employes. When these results were evaluated and correlated with our work in the plant, it was found that a number of employes had a hearing loss at noise levels considerably below the damage risk level of 110 decibels now being proposed. This gives us reason to believe that noise levels well below 110 decibels may cause hearing loss in some individuals.

Motivated by the recent court decisions and the financial implications involved, many industries have instituted pre-employment audiometric examinations and occasional screening programs to determine the extent of the risk. Much can be done in the control of industrial noise, and the Division of Occupational Health has assisted many industries throughout the state in surveying their operations and controlling specific noise sources.

In-Plant Medical Services

Cultivating full-time or part-time in-plant medical services in industry is an integral part of the occupational health activity. The opportunities of the industrial physician and nurse to elevate the health and well-being of a large segment of the adult population are so real and positive they excite the imagination of all public health people. However, from our twenty years of experience in promoting industrial medical services, we have encountered some substantial difficulties.

In large industries with 5,000 or more employes, the need and advantages of an in-plant medical service are self-evident. In fact, full-time or some form of part-time medical services already exist in these plants with very few exceptions. But this type of plant represents only a small percentage of the total number of manufacturing plants and a still smaller percentage among the 29,000 employers in the state. In Michigan, over 94 per cent of the industries have less than 250 employes, and 81 per cent have less than fifty employes!

The large industry is in a position to use in-plant medical service to practical advantage, and the costs can be spread over a large number of employes and production operations. Increased production levels through better health and low incidence of absenteeism are weak arguments to a small employer who already maintains a high production level and controls his absenteeism by personal selection, retaining only the "steady" employe.

In promoting in-plant medical service, we have

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Responsibility of the Surgeon in the Restoration of the Industrially Injured Patient to His Maximum Earning Power

By W. L. Estes, Jr., M.D.
Bethlehem, Pennsylvania

IT has long been recognized that complete recovery from injury depends not only upon accurate and adequate treatment of the injury itself, but also upon the successful enlistment of the active participation of the patient in obtaining restoration of full function of the injured part. It is likewise accepted that the surgeon is responsible for the effective application of both these elements of therapy. With the advent of present-day rehabilitation, with the added techniques for restoration of function and numerous experts for their application, wider horizons of aid in attaining more efficient end results have been developed. It would seem timely, then, to review the effectiveness of the recovery program of trauma casualties and to re-evaluate the position and responsibility of the surgeon toward complete recovery of the injured.

Information as to the efficiency of the overall treatment of the injured and how ideally it has been pursued is difficult to ascertain. There seem to be but few reports of comprehensive end results, except in the case of certain specific injuries, such as fractures, dislocations, head or abdominal trauma. Certainly, the experience of experts in physical medicine indicates that reference of patients for aid in recovery of function is still often late at a time when contractures of joints have already occurred.[5]

End results, as viewed in casualty insurance clinics, which check over cases of delayed or prolonged recovery, tend to demonstrate that the contributing factors to poor results are:

1. Inferior surgery—frequently by men inadequately trained in the treatment of Trauma-coupled with:
   (a) Insufficient immobilization of fractures
   (b) Prolonged splinting without concomitant muscle training.
2. Lack of early active motion and exercise
3. Fixed neuroses.

One large casualty company, the Liberty Mutual, reports 34 per cent of patients referred late (seven months or more after injury) to their clinic cannot be fully rehabilitated. The injuries are too old, the soft tissues too fixed, and nerve injuries too long unrecognized. Some may be improved by additional surgery, and others have continuing disability, largely because of delay in rehabilitation as a result of litigation.[1]

In 1951, 4,430 persons injured on the job while under Workmen's Compensation were returned to work under the federal state program of vocational rehabilitation. The average time, however, between injury and referral to the vocational rehabilitation agencies was seven years.[6]

On the other hand, the care by large industrial corporations of its injured may be close to ideal with a well-co-ordinated group of medical experts, prepared to carry out the entire recovery program from treatment of the injury and recovery of function to the return of full earning power. Good team work of the participants is easy. High percentage of satisfactory recovery can be expected. The institution of early return to work can be a powerful factor toward success. Carefully supervised return to a job after injury is the most effective psychological stimulus toward maximum and enthusiastic participation of the injured in his own recovery. Under these circumstances, litigation largely concerns those with permanent injuries to appraise the degree of disability upon which to base the amount of compensation deserved or justified.

For casualties occurring in small industries or as a result of accidents on the highway or in the home, the assembly of sufficient ancillary services to complete rehabilitation of the severely injured may tax the ingenuity of the surgeon. An expert in physical medicine or occupational therapy may not be available or rehabilitation centers not within easy reach.

It would seem, therefore, that to date, the application of a regime for satisfactory treatment of the injured in some areas still leaves something to be desired.

The deficiencies, as revealed, may be listed as follows:

1. Actual inept primary or inferior definitive surgery.

Presented at the annual session of the Michigan State Medical Society, Detroit, September 29-October 1, 1954.

2. Delay in active use of the injured part by the patient accompanied not infrequently by neuroses.
3. Delay in consultation with physiatrist or in employment of physical medical or rehabilitation techniques.
4. No direction or oversight for eventual regain of full earning power.
5. Lack of team work between surgeon and the restoration of function services.
6. Delay in recovery of function because of litigation.

To eliminate these deficiencies in present-day practice should be the object of any plan of action. The procedure must be patterned after that established by many large industrial corporation medical departments where the team work of a group of experts, presided over by the surgeon, handles the injured from the actual time of trauma to the return to his job or maximum earning power.

The overall plan should include:

1. Excellent primary surgery.
   It should be axiomatic that surgeons undertaking the care of trauma must be competent in the techniques and therapeutic management of severe injuries. Many opportunities to obtain adequate training in the surgery of trauma, particularly at the postgraduate level, now exist. In larger hospitals, care of the injured should be channeled to those who have demonstrated efficiency in the therapy of trauma.

2. *Early* active participation of patient in recovery of function.
   Active use of muscles of the injured part may often be begun on the day of the accident itself. The patient's enthusiastic co-operation may be stimulated by:
   (a) A brief explanation that he himself is the active agent by which recovery of function is obtained and an outline of the nature of the injury and the method of recovery.
   (b) Information that in severe injuries and prolonged convalescence every effort will be made:
      (1) To obtain maximum return of function and earning power.
      (2) To help solve any family problem resulting from his injury.
      (3) To enlist a corps of experts if necessary to effect recovery.
      However, many injured may be successfully restored to full function by excellent surgery and well-directed active use of the injured part with little need for any other ancillary aid.
3. *Early use* of physical medical techniques when necessary for recovery of function. The longer the disability the greater the maladjustment.
4. Social service when indicated for aid in family problems.
5. Early planning of a team of experts, needed for aid in the patient's recovery, to include any of the surgical specialties, a psychiatrist, or experts in vocational training, prosthesis fitting et cetera.
6. Use of the rehabilitation center.
7. *Overall oversight* of the injured by the *surgeon* until final return to work in order to:
   (a) Judge the efficiency of the recovery program.
   (b) Decide whether late surgery may be indicated.

In many permanently injured, to obtain the best functional result, the late stage of recovery may require largely rehabilitation supervision, but even here the surgeon should never lose complete contact.

There should be an opportunity for consultation of the experts involved in difficult cases. Review of progress of all cases should be routinely checked. When possible seminars for the demonstration and discussion of problem cases should be instituted.

At times, there may be difficulty in obtaining needed experts or facilities, such as vocational training or psychiatrists or rehabilitation centers. State medical societies, through specific councils or commissions, may be sources for access to *needed* services. In Pennsylvania, the Council on Physical Medicine and Rehabilitation of the Pennsylvania State Society stands ready to act as consultant or Bureau of Information to the individual surgeon on any specific problem. The State Medical Society can also lend its influence toward the establishment of rehabilitation centers organized under proper ethical and efficiency standards.

It is obvious that the advent of new techniques for the restoration of the injured has placed a greater and increasing responsibility upon the surgeon. Not only must the patient's injuries be mended, his co-operation enlisted to regain use of the injured part, but all the modern facilities for

restoration of the man himself to gainful employment must be understood and applied, "The surgeon must learn how to administer the most efficient type of after-care or to utilize the services of those capable of so doing."[2] The aim is not merely the recovery from injury with the greatest possible return of function, but also the return to the injured of maximum earning power.

The responsibility of the surgeon should extend, therefore, over the entire period of disability to the end that the patient is restored to gainful employment at his highest attainable skill.

Change in Workmen's Compensation Laws

An important factor that militates against the full use of modern rehabilitation for the injured worker is the workmen's compensation laws of today. These laws emphasize the remuneration of the injured for loss of wages while recovering from injury, the care of the injured until recovery, and payment of compensation for any permanent disability incurred. Often, if litigation is involved, years may pass until final payment or full remuneration is obtained, during which time rehabilitation ceases until settlement is made—a time that might more profitably be employed in treatment for full recovery of maximum function, an interval that if lost for rehabilitation frequently cannot be regained, an interval in which fixation of joints and atrophy of muscles without therapy becomes permanent. "The injured so often winds up with a much desired sum of money which he spends and a disability which he keeps."[2]

Under present compensation laws, the potentialities of present-day rehabilitation are ignored and find no place. Little thought to any phase of rehabilitation is given by most persons connected with workmen's compensation. A general lack of interest in the problem prevails at the level where interest could be most effective.

The need for unremitting efforts until maximum restoration of function and earning power has been obtained is completely blotted out by the false goal of maximum remuneration for injury incurred as the primary desideratum for the injured. In fact, it has been said, "True rehabilitation of the injured worker, with a few real exceptions, is from a practical point of view virtually non-existent under our present workmen's compensation system."[2]

Rehabilitation of the injured is certainly the responsibility of the medical profession. If existing compensation laws interfere with the complete application of modern rehabilitation techniques and prevent the full potential of modern rehabilitation, should not the surgeon assume leadership in setting machinery in motion to obtain a change in the compensation laws to include as a basic concept the maximum rehabilitation of the injured worker?

The American College of Surgeons, through a sub-committee of its Committee on Trauma, of which sub-committee, Dr. Alexander Aitken of Boston is chairman, has discussed informally with representatives of labor and industry and insurance carriers, fundamental principles upon which changes in the laws should be based.

These principles have been listed as:

1. Rehabilitation of the injured worker and his return to gainful employment should be the basic concept in an improved workmen's compensation system. It is recognized that the disabled worker wants to be rehabilitated and restored to gainful employment. Settlement of cases on a basis of cash awards alone does not meet the continuing needs of the injured worker and his family.

2. The need for higher standards and broadened benefits in workmen's compensation is recognized; such standards and benefits should be developed against the background of presently known advances in physical restoration and vocational rehabilitation and adequate standards of individual and family need.

3. Full utilization of all our potential manpower is essential to the welfare and strength of the country at all times. The discarding of disabled workers is an economic extravagance detrimental to the welfare of our country, wholly aside from the personal effect on the worker and his family. Solution of the problems of trauma requires co-operation and not competition, between all interested groups and agencies. We must therefore, improve and expand all activities, public and private, that aid in rehabilitation of the disabled worker.

4. The medical profession should adopt the concept that the responsibilities of the treating physician extend over the entire period of disability to the end that the patient is restored to gainful employment at his highest attainable skill.

5. Rehabilitation and restoration to gainful employment of the injured worker must begin with first aid and continue throughout the period of disability. In order for a physician to carry out this responsibility, it is essential for him to recognize the total medical problem of the patient in addition to his injury, as well as his personal problems. The physician must bring to bear on these problems all the skills and disciplines that science and society can offer, and utilize all community resources which can assist him in the accomplishment of these objectives.[3]

Attainment of these basic principles can be accomplished only by changes in the administra-

tive rules of procedure or in the compensation laws themselves.

Provision must be made for:

1. Complete and continuous medical care from the date of injury or disability to maximal restoration of function.
2. Complete medical rehabilitation
3. Adequate compensation to insure family security during the entire period of disability and rehabilitation.

The medical profession with its knowledge of the far-reaching potentialities of rehabilitation should continue leadership in obtaining the co-operation of labor and industry in acquiring compensation laws under which the injured may receive the maximum benefit of modern rehabilitation techniques.

Conclusions

The responsibility of the surgeon in the care of the injured must include:

1. Excellent surgery in repair of the injury itself.
2. *Immediate* enlistment of the patient's active participation in the recovery of function.
3. A study of the patient himself and search for any economic or social problem that concerns his or his family's welfare.
4. The *early use* of the techniques of physical medicine when necessary for muscle training and co-ordination.
5. Consultation with experts in vocational and occupational therapy or with other surgical specialists or psychiatrists, for a planned regime of rehabilitation to restore maximum earning power.
6. Extending the responsibility of the surgeon over the entire period of disability to the end that the patient is restored to gainful employment at his highest attainable skill.
7. Change in compensation laws to recognize the potential of modern rehabilitation procedure for restoration of the injured, and to avoid litigation that interferes with or prevents complete recovery of function.

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FROM CARPET TACKS TO CARGO SHIPS

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attempted to concentrate our efforts in that segment of industry amenable to it; that is, we consider such factors as size of plant, type of operations, location of plant, et cetera. Other industries may be served to better advantage through private industrial physicians and in some areas by the small industrial clinic.

The foregoing is a brief summary of a few common and persistent occupational disease problems in our state. As previously pointed out, the extent and variety of manufacturing in Michigan approaches encyclopedic proportions, running all the way from carpet tacks to cargo ships and from polio vaccine to wall-paper paste. This variety and the ever-increasing industrialization of the state make the occupational disease prevention program complicated and difficult to promote.

Michigan's Division of Occupational Health compares favorably with similar units throughout the country in organization, personnel, laboratory facilities and industrial coverage. The field staff of the Division will make close to 4500 industrial visits this year. Due to the magnitude of the problem, it is essential to have the co-operation of practicing physicians and all other groups interested in occupational health. The reporting of occupational diseases, as required by law, is a source of valuable information in directing our efforts. As provided by statute, the specific cases of occupational diseases reported are confidential, but the statistical data they provide are of inestimable assistance in directing our organization and efforts in the most effective channels. The Michigan Department of Health, upon request, will provide information and occupational disease reporting blanks to those physicians who wish them.

Vocational Rehabilitation in Michigan

By Edward F. Sladek, M.D.
Traverse City, Michigan

THE CONCEPTION that there was a possibility of increasing the earning power and changing the status of a severely handicapped individual from dependency to independence was developed following World War I. Offices of Vocational Rehabilitation were established in each of the states financed by equal matching state and federal funds. The program was entirely educational, training the handicapped individual in some vocation through which he could re-establish earning power and support himself and his family instead of depending upon public charity.

In 1943, it was realized that many of these individuals were handicapped by physical conditions which could be corrected and removed by modern medical science. As a result, the Office of Vocational Rehabilitation embarked upon an additional program of physical restoration with each state office developing a plan of standards, requirements, and procedures which were submitted to Washington for approval. In Michigan, a series of meetings between a committee of the Michigan State Medical Society and the officials of the Office of Vocational Rehabilitation, Department of Public Instruction, greatly assisted in establishing the Michigan Plan on a sound, realistic and workable basis, and the physical restoration services were instituted.

Objective

The ultimate objective of medical services is to restore the handicapped individual to his maximum physical function. If necessary, additional services are offered either in placement in a job he can do, the supplying of occupational tools or equipment, or training in some occupation best fitted to minimize the deleterious effects of that individual's physical handicap. Thus, the door is opened for opportunities for patients who formerly were considered to be "hopelessly helpless."

The Office of Vocational Rehabilitation definitely is not another governmental agency through which physicians can be paid for surgical or medical services to patients who are not able to pay for these. The individual who becomes a recipient of Vocational Rehabilitation services must first establish the presence of some physical defect which has been and still is a vocational handicap and which either prevents him from earning a living, obtaining employment, or greatly reduces his earning capacity. Where correctable physical restoration is recommended, it must be established that the individual is unable to pay for the procedure.

Processing an Application

The initial requirement in the processing of an applicant is a complete general medical examination. Preferably, this is done by the family physician who must be a doctor of medicine. This general medical examination should bring to emphasis, (1) the physical condition which is an occupational handicap and an opinion as to why this interferes with the individual working; (2) a recommendation for corrective professional services, surgical, medical, x-ray, laboratory, specialist examinations, or prosthesis; (3) an opinion as to whether the individual is able to work full time or part time in his present physical condition and whether medical correction of the handicapping condition is possible and would result in the individual again becoming employable; and (4) the presence of additional physical conditions which might have a bearing on a future planned program of either physical restoration or training for occupational employment.

The general medical examination report is referred to the medical consultant of the district office for study and analysis. If he feels that the report is sufficiently clear to establish the presence of a physical handicap which is stable and correctable and not chronic and progressive, he may immediately approve the recommended physical restoration services. If, from his study of the general medical report, he is uncertain as to the diagnosis or the correctability of the handicapping condition, he may order additional studies by certified specialists (this usually results from incomplete reports by the examining physician). If the applicant does have a physical handicap which is not correctable but which definitely interferes with earning ability, the medical consultant may approve a training program in a new occupation commensurate with the limitations of the handicap. Payment for medical services is based on the Uniform Fee Schedule for Governmental Agencies.

In the meantime, a field agent of the regional

(Continued on Page 958)

Legal Situations Confronting Industrial Physicians

By Carey P. McCord, M.D.
Ann Arbor, Michigan

IT is not known that there are laws or official regulations exclusively directed to industrial physicians. Yet, there are some legal situations more likely to confront the industrial physician than others in the medical profession. Three unrelated items are here presented, all serving to remind the industrial physician that their activities are attended by legal requirements and on occasion, legal jeopardy.

Malpractice Claims Against the Industrial Physician

Over the years, a point of law bandied about relates to the vulnerability of the industrial physician to malpractice suits on the part of medically treated workmen who have received the appropriate benefits of workman's compensation. The consensus developed among skilled attorneys long has been that rightly the disgruntled or clearly maltreated workman-patient once having elected the coverage of compensation is without further opportunity at law. Through legislative enactment in the State of Michigan (1952) (with the possibility of similar interpretation of existing laws in some other states), all uncertainty is removed on that score. Regardless of acceptation of compensation benefits, the industrial physician or any physician carrying out treatment as provided under compensation enactments is subject to malpractice suits. In some quarters, this smacks of being in the nature of an additional fringe benefit. Thus, it becomes patent that even on the basis of whim or caprice, any industrial physician may be sued at the will of any workman-patient on the slightest pretext of misfeasance, malfeasance, or non-feasance. To make the matter even more complex and threatening to the industrial physician, it comes about through current legal interpretation rather than through any known statutory enactment that although the physician be employed on a full-time basis by industrial management or otherwise on salary, his position as to malpractice claims is not one of agent of the employer. The physician alone becomes responsible for his medical acts. The theory behind such interpretations springs from the well-established dictum that a corporation may not practice medicine. Some uncertainty attends the position of the full-time employed industrial nurse and the degree of responsibility of the physician in charge of industrial nurses and other assistants employed by industry. However, there may be less uncertainty that the corporation employer of a nurse may itself be saddled with financial onus as to malactivities, real or fabricated, of the industrial nurse. Professionally, she may not act as an agent of management. By any reckoning, the industrial physician finds himself holding something besides his emergency bag. By way of protection, it is suggested that industrial physicians may do well to consider the desirability of seeking as a part of the financial arrangements as to employment, paid-up malpractice insurance year by year. In lieu of this possibility, the physician himself in order to sleep well at night might obtain at his own expense, suitable protective coverage. In this day, the traditional $5,000 to $15,000 policy is a driblet. The $100,000 policy is closer to the jeopardy. In any case, keep quiet about it. Known malpractice coverage is a direct invitation to lawsuits. The usual and oftentimes misguided jury, when it brings in a verdict favorable to the plaintiff, has the quaint practice of making the award never less than the amount of known protective insurance. Of course, mention in the courtroom of knowledge of existing protective insurance may then and there become the basis of demand for mistrial. (Based on an editorial in *Industrial Medicine and Surgery,* May, 1954).

Occupational Disease Reporting

Within the State of Michigan, there exists a legal requirement necessitating the prompt reporting of all occupational diseases. One paragraph of that enactment is quoted:

"Section 17.431. Occupational diseases; reports by physicians, et cetera, contents; use as public records. '. . . every physician, hospital superintendent, or clinic registrar having knowledge of a case of occupational disease shall within ten (10) days report the same to the state department of health on a form provided by the state department of health, giving. . . . All such reports and all records and data of the state department of health pertaining to such diseases are hereby declared not to be public records. The department of labor and industry shall have access to any such record in any case where any complaint or suit shall have been brought before.' "

It is regrettable that this law is not heeded by all physicians. Similar laws exist in most other states and, with one or two exceptions, are not enforced. The current statistics for Michigan (March, 1955) reveal only fourteen instances of occupational disease during that month. It may be believed that from any one large, general hospital within the state that number of reports of occupational diseases might have derived. Likewise, many individual physicians within the state in a single month have within their care at least that number of occupational disease conditions. In the United States, there do not exist and never have existed any reliable figures as to the incidence of occupational diseases. If, faithfully, all occupational diseases were reported, this defection promptly would disappear. Among other deterrents to the living-up to this legal requirement of occupational disease reporting are:

1. Many occupational diseases are not immediately diagnosable as such and thus are dissimilar to the readily determined traumatic injuries. Some occupational diseases are not adjudged so to be except by court action and even then the physician may not acquiesce in the diagnosis.

2. The usual occupational disease frequently is so diagnosed, not by the plant physician but by some consultant or by some hospital staff. The plant physician may assume that the consultant or hospital will make the report, while the consultant or hospital group may assume that the plant physician will accept the legal responsibility.

3. Some occupational diseases, such as the pneumoconioses, may be detected among work applicants or employes with full evidence that the condition originated in other employment and perhaps in other states. Thus, an ex-coal miner from Pennsylvania, on application for new employment in Michigan, may present an early and non-disabling stage of silicosis. The plant physician, recognizing this state, usually elects "no report" lest in some manner the prospective new employer acquire some degree of responsibility. This attitude is almost certain in case an applicant is refused employment for any cause. Of course, the real reason for scanty occupational disease reporting is the same physician lethargy that curtails all disease reporting.

It is unlikely that any Michigan physician runs any risk of fines or imprisonment because of failure to report occupational diseases. Notwithstanding, as a professional and ethical duty, it will prove most helpful if all physicians faithfully report occupational diseases so that there may come about a more exact knowledge of the true incidence of these trade diseases.

Physicians' Legal Duties Regarding Deaths on Plant Premises

Fortunately, death among workmen is so infrequent that any routine of procedures is likely to be lost sight of because of this rarity. Still, there are legal requirements not precisely imposed upon the industrial physician, but he it is who becomes chiefly responsible. By law or regulation, it is requisite first that the victim be pronounced dead, and this may be done only by a physician. This is a legal requirement, even when the victim obviously is dead. Legal requirements necessitate reporting to the police department all sudden deaths, even though there be no evidence of violence or crime. A third necessity is an immediate report to the office of the coroner. It is often presumed that if the police be called, that agency will call the coroner, or just the reverse, that the coroner's office will notify police. This assumption does not meet legal requirements in most jurisdictions. Both agencies must be notified. The above may meet the strictly legal demands, but there are other acts not necessarily within the domain of the industrial physician but often falling to his lot. These are:

1. Although not always possible, the body should be left at the point of discovery of death until its removal is directed by the coroner or police official.

2. If the victim be known to be of Roman Catholic faith, a priest should be called.

3. Prompt arrangements should be made to notify the family of the victim and preferably through a visit to the home rather than by telephone.

4. Promptly, effort should be made to safeguard the personal belongings of the dead party. Over and over, claims are made by relatives of all manner of losses of money, tools, clothing, et cetera. However, unwarranted these claims may be, much can be gained by collection of all items of personal property, even such trivial items as lunch boxes.

(Continued on Page 956)

Acute Pericarditis Associated with Serum Sickness Due to Injection of Tetanus Antitoxin

By Douglas Donald, M.D., and
Martin Crotty, M.D.
Detroit, Michigan

IN FEBRUARY, 1954, Goldman and Lau[1] reported two cases of acute pericarditis associated with serum sickness following the injection of tetanus antitoxin and reviewed the literature, which was scant. Since then, no further cases have appeared in the literature. The following case is presented because the patient gave a previous history of sensitivity to tetanus antitoxin and the typical pericarditis noted here with friction rub and later fluid in the pericardium seems without doubt to be due to serum sickness.

A white man, aged forty-one, was admitted to Jennings Memorial Hospital on April 20, 1954, because of a traumatic amputation of the fifth digit of the right hand by an automatic shear. History was negative for any serious illness. On physical examination, the only abnormal finding was the almost completely severed digit. Temperature was 98° F, pulse 80 and regular, respirations 20 and the blood pressure 140/80. Urinalysis was normal. Examination of the blood showed a red cell count of 4,500,000 with a hemoglobin of 13.3 gm. per 100 cc. and a white cell count of 16,750 with 90 per cent neutrophils, 7 per cent lymphocytes, 2 per cent monocytes and 1 per cent eosinophils.

On the day of admission, a plastic repair of the traumatic amputation was performed by Dr. J. B. Hartzell under general anesthesia. Atropine gr. 1/150 was given intravenously as premedication. Anesthetics used were Thiepentothal, 2.5 per cent intravenously, and nitrous oxide and oxygen.

Postoperatively, the patient was given tetanus antitoxin 1,500 units in divided doses because of a history of a mild reaction to an injection of tetanus antitoxin some years previously. He was also started on Benadryl 50 mgs. every four hours prophylactively and on procaine penicillin 400,000 units and streptomycin 0.5 gm. every four hours.

On April 21, his temperature was 101° F, pulse 100 and respirations were 20. He had no specific complaints. Penicillin and streptomycin were discontinued.

On April 22, his temperature was 101° F, pulse was 100, and respirations were up to 26. He complained of stiffness in his jaws, which he said was similar to the reaction he had to the previous injection of tetanus antitoxin. Later in the day, he had fairly severe substernal pain made worse by respiration. Physical examination resulted in no unusual findings.

On April 23, his temperature was 101, pulse rate 120, and respirations were 30. He still had intermittent soreness in the chest. Roentgenogram of the chest disclosed normal heart and lungs. White blood count was 15,000 with 82 per cent neutrophils, 16 per cent lymphocytes, 1 per cent monocytes and 3 per cent eosinophils. Electrocardiogram (Fig. 1) showed definite elevation of R-T in I and II and in V leads, suggesting an acute pericarditis.

On April 24, his temperature was 102° F, pulse rate 100, and respirations 28. On physical examination, a loud precordial friction rub was heard all over the precordium.

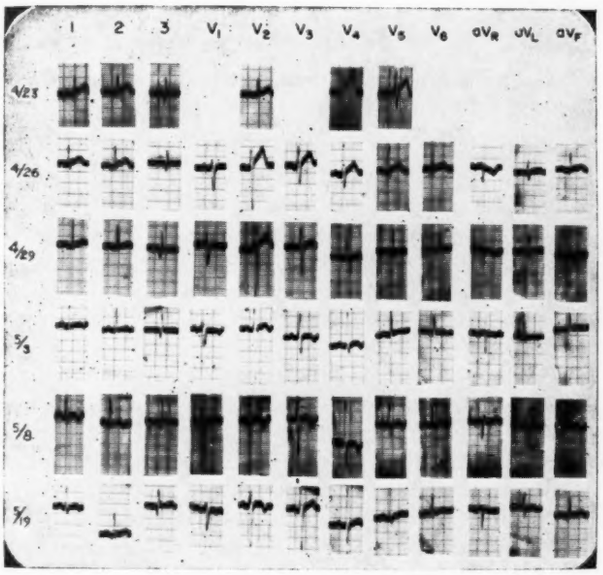

Fig. 1. Serial electrocardiogram showing tracings taken on the 3rd, 5th, 9th, 13th, 18th, and 29th days after the injections of tetanus antitoxin were given. Elevation of the R-T segments in leads I and II and the precordial leads is noted. This elevation later disappears and T inversion appears in I, II and the precordial leads.

The white blood count was 13,500 with 79 per cent neutrophils, 11 per cent lymphoctyes, 6 per cent monocytes and 4 per cent eosinophils. Fluoroscopy of the chest revealed a beginning pericardial effusion. Electrocardiogram revealed slightly less elevation of S-T segment in I, II and V leads.

On April 25, temperature was 102° F, pulse rate 110, respirations were 30. The patient continued to have intermittent episodes of chest pain and generalized aches. Precordial friction rub was present. He was started on Chloramphenicol 0.5 gm. every four hours.

On April 26, temperature was 101° F, pulse rate 100, respirations 22. He had generalized aches and anorexia, nausea and precordial pain. Friction rub was no longer heard. He was given 40 units of ACTH, I.M.

On April 27, temperature was 98° F, pulse was 90,

From Jennings Memorial Hospital, Detroit, Michigan. Dr. Crotty is now serving in the Armed Forces of the United States.

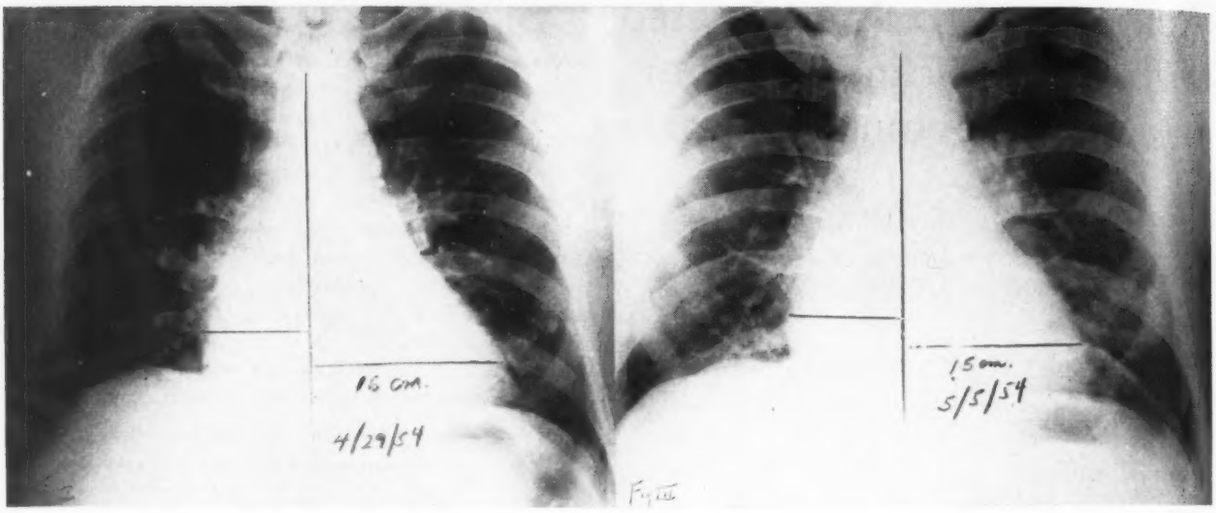

Fig. 2. X-ray showing some precordial effusion. Transverse diameter of cardiac silhouette 16 cm.

Fig. 3. X-ray showing transverse diameter of cardiac silhouette to be 15 cm. and some change in the configuration.

respirations 20. He had much less pain. He was given 25 units ACTH, I.M.

On April 28, temperature was 98° F, pulse 80, respirations 20. He felt very well. ACTH was discontinued. He maintained the clinical improvement and remained afebrile until May 1.

Serial electrocardiograms revealed changes reverting to normal (Fig. 1). Serial roentgenograms of the chest revealed decreasing size of cardiac silhouette consistent with resorption of the pericardial fluid. The leukocytosis also fell gradually. On April 30 Chloramphenicol and Diphenhydramine were discontinued.

On May 1, there was a recurrence of the symptoms, severe substernal pain, anorexia, vomiting and with temperature elevated to 101. Pulse rate was 100 and respiration rate was 36. Physical examination revealed widening of the area of cardiac dullness, heart tones were soft, no friction rub was heard. This was interpreted as a rebound phenomenon due to the too abrupt or too early discontinuance of ACTH. ACTH 25 units, I.M. daily was given, and after two days there was a complete subsidence of the symptoms, and the patient became afebrile again. The further clinical course was uneventful, and the patient was discharged on May 9, 1954.

This case is presented because, though there is little in the literature regarding the incidence of pericarditis as a part of serum sickness, it must occur more often than recognized.

As Goldman and Lau pointed out, it seems logical that the pericardium, a serous surface, may as well be involved in serum sickness as other serous surfaces, such as the joints.

Reference

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LEGAL SITUATIONS CONFRONTING INDUSTRIAL PHYSICIANS

(Continued from Page 954)

5. Manifestly, the physician's office or some other suitable agency, such as the Safety Department, should investigate and provide records as to the time, place, circumstances of the death and, if possible, list witnesses thereto. The experienced industrial physician will have readily available in his office a schedule of the prompt action to be taken in the instances of death on the premises.

Few industrial physicians are fully aware of the wide variety of legal measures that attend their activities. The three described are but representative.

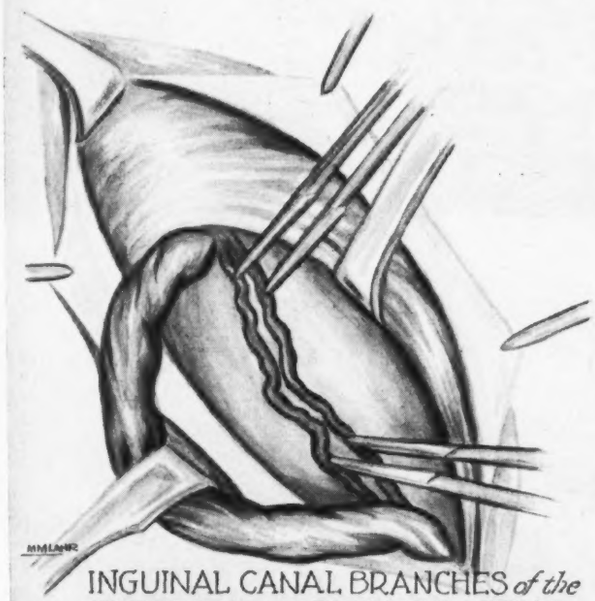
A Simple Adjunct in the Treatment of Inguinal Hernia

By Lloyd F. Teter, M.D.
Pekin, Illinois

HISTORY relates that the treatment of hernia began with the Phoenicians in 900 B.C.[2] Since that time, many hundreds of operations have been described for the treatment of this condition, and all have had their relative successes and failures. It is not the purpose of this paper to claim a new and startling operation for the treatment of inguinal hernia. It is, however, the thought of the author that by including the following simple procedure, the surgeon will obtain better end results and less recurrences in the routine repair of inguinal hernia.

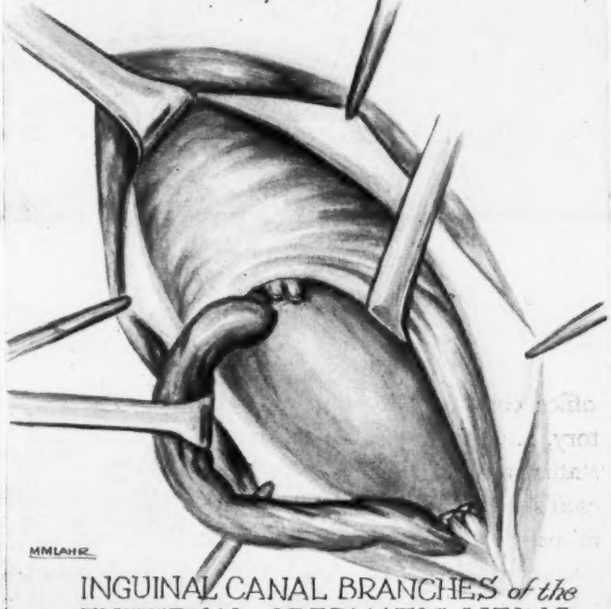
The author for many years has advocated that the inguinal canal branches of the external spermatic veins be ligated and excised routinely in the treatment of inguinal herniae. It is his opinion that this vein (or veins as vessel is found in multiples of two to four at times) should be clamped ligated, excised its entire length along the floor of the inguinal canal. Unless ligated and excised as described, this vessel could be a factor in hernial recurrence by interposition of soft tissue between facial layers. This procedure prevents troublesome bleeding and releases many adhesions between the spermatic cord and the floor of the inguinal canal. In cases where a short cord persists, the freeing of adhesions increases mobility of the cord and its structures and thus facilitates hernial repair.

Figure 1.



INGUINAL CANAL BRANCHES *of the* EXTERNAL SPERMATIC VEINS CLAMPED

Figure 2.



INGUINAL CANAL BRANCHES *of the* EXTERNAL SPERMATIC VEINS LIGATED *and* EXCISED

Anatomy

The inguinal canal branch or branches of the external spermatic vein are found behind the spermatic cord coursing obliquely over the ventral surface of the conjoined tendon which forms the posterior wall of the inguinal canal, and there the vessels communicate with the pampinform plexus in the region of the external inguinal ring. This inguinal canal branch is exposed and frequently torn during an inguinal herinorrhaphy, when the spermatic cord is retracted forward and downward to expose the conjoined tendon and posterior inguinal canal. These branches can be easily ligated above, below, and behind the retracted cord and the veins should be excised "en masse" in their entirety along the floor of the canal.

Operative Procedure

The surgeon carries out his regular incision for inguinal hernia and routine procedure for expo-

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sure of the inguinal canal. The inguinal branches of the external spermatic veins are visualized by retracting the cord forward and downward as shown in Figures 1 and 2. The vessels are clamped, ligated, and excised as shown in Figure 2. The operator then proceeds with his routine inguinal hernial repair.

Comment

Zimmerman[3] has stated in his excellent article that the lower borders of the cremasteric muscle should be divided at the internal ring to obtain better exposure at the site but to divide the muscle carefully between ligatures because of the presence of a good-sized vein. This vein is the inguinal canal branch of the external spermatic veins, which should be ligated above and below as previously described.

Summary

A review of the venous supply of the floor of the inguinal canal is presented. By ligation and excision of the inguinal branch of the external spermatic veins as described, there is less bleeding, greater mobility of the spermatic cord and less recurrences of inguinal hernia. This procedure applies to both direct and indirect type of inguinal herniae. Casual search through the literature and textbooks failed to reveal a description of the above procedure.

Acknowledgment

The author wishes to thank Dr. Darvan A. Mooseman, Department of Anatomy, University of Michigan, and acknowledge the description of blood supply of the inguinal canal as presented in this article. Acknowledgment and thanks to Mrs. Marian Lahr, Librarian, Leila Hospital, for the excellent illustrations shown in this article.

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VOCATIONAL REHABILITATION IN MICHIGAN

(Continued from Page 952)

office contacts the applicant, obtains a work history, analyzes the family relations, needs, financial status, and particularly the impact of the applicant's handicap on these factors. He often administers intelligence, aptitude and interests tests and counsels as to possible future occupational endeavors which would fit the physical handicap. This counseling, in an attempt to fit the individual's handicap and ability to a suitable occupation, is a most important function of the field agent.

After it is determined that an applicant qualifies for services from both the medical and sociologic aspects, a "plan" is formulated. This plan may consist of an order for physical restoration services to be rendered by the doctor of medicine of the client's choice, or arrangements made for training in a new occupation, or in many instances both of these services. Final approval of the plan is given by the state office in Lansing.

Experience

Vocational rehabilitation services are available in all counties of the state through eight district offices. Also, there is an office at the University Hospital which, with the general hospital staff and the new Division of Physical Medicine, is developing a program of rehabilitation for severely disabled individuals. A medical consultant is available at all times at each district office.

During the fiscal year 1952-53, 3,100 individuals qualified for and were given vocational rehabilitation services. The average weekly earnings before services were $5.34; after service, $47.48. This represents an increase in purchasing power of the rehabilitated of approximately $6,000,000 at a total cost to the state and federal governments of $1,358,000. Of these, 935 received surgical, medical, psychiatric and dental services; 1,017 were supplied with appliances, artificial limbs, braces, hearing aids, or glasses; 489 were hospitalized. About 2,900 received some form of educational training in occupations best fitted to their physical handicap.

Summary

Because of recent increased interest in vocational rehabilitation at the federal level, it is felt that the doctors of Michigan should become better acquainted with the program and its objectives, thereby being in a position to render better service and co-operation to handicapped citizens.

The Administrator's Place in Psychiatry

By Arthur P. Noyes, M.D.
Norristown, Pennsylvania

THE title selected for this paper suggests that discussion will be limited to a consideration of the functions of directing either a hospital for the care and treatment of the mentally ill or some other agency concerned more or less directly with such a function. This will be the principal topic of discussion, yet perhaps some brief historical references may be permissible. In discussing the role of the administrator, I wish to emphasize that his policies should be determined by considerations of therapy rather than by those of economics and discipline, inescapable as these may be in the public mental hospital.

Apparently Hippocrates and his followers believed that mental disorders, like physical illnesses, were strictly natural phenomena. His medical psychology was based on the assumption of a disturbance of physiological processes. He strove to liberate psychiatry from mystical prejudice and toward a unified, biological point of view. There are few records available, however, to show how mental patients were cared for during the Hippocratic era. There is some evidence that would show that asylums did exist. Five hundred years later, A.D. 195, a Greek writer, Coelius Aurelianus, recommended measures that, for the most part, did not find general acceptance until sixteen centuries later. In speaking of the treatment then in vogue, he was apparently justifiably quite critical of physicians: "They seem," he said, "rather to lose their own reason than to be disposed to cure their patients when they liken them to wild beasts who must be tamed by the deprivation of food and the torments of thirst. Misled, doubtless, by the same error, they advise the inhuman use of chains, not considering how their members may be lacerated or broken and how much better it is to control by the hands of men than by the often useless weight of iron . . . means of repression employed without judgment increase and may even give rise to furor instead of repressing it." (Zilboorg)

Gradually many forces led to patterns of culture and thought in which the goal of life became a personal, mystic salvation and led to a demonological psychiatry. Thus the field of mental diseases was diassociated from medicine and continued so for nearly twelve centuries. The medical man dared not look independently into either normal or abnormal psychology. Physical illnesses might be natural but mental illnesses were supernatural. For the most the mentally sick continued to be considered as not only hopeless but bad people who came from evil, carried evil in themselves and brought evil on others. Demonology continued therefore to bring down upon the mentally ill the full weight of human cruelty. The mentally sick who escaped the fate of being burned or hanged as witches were scarcely more fortunate. They were the outcasts of society and wandered over the countryside seeking shelter in stables and pigsties. People mocked at them, beat and tortured them. If apprehended and interned, the mentally sick were placed side by side with murderers and other criminals in chains. The criminal would serve his term or be liberated by execution, but the insane could not secure liberation even by fire at the stake.

Until near the end of the eighteenth century this was the status of the majority of the places where the insane were confined. To be sure there were places where the mentally ill were kept, but there were no places properly organized for the purpose of taking care of or treating them. In the early colonial days of America no attention was paid to mental illness until persons thus afflicted required supervision or confinement. Some practical measure was then taken to protect the community from a public nuisance. The insane, therefore, soon became identified with criminals and paupers and, when violent, were put in jails or confined in cages in poorhouses. It is a matter of pride to Pennsylvanians that a hospital, the first in America, was established in Philadelphia and that its charter provided not only for the relief of the physically sick but also for the "reception and cure of lunaticks." To be sure the provision at the Pennsylvania Hospital consisted merely of cells in the basement and was only intended for persons who required custodial care. To Virginia, however, belongs the honor of providing in 1773 the first public hospital in America used exclusively for the insane. Very little else was done in America during the remainder of the eighteenth century in making constructive provision for patients who should have received institutional care.

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Perhaps I shall be pardoned if I digress to call attention to the fact that it was a period, however, that produced three persons who occupy very significant places in the history of psychiatry —Benjamin Rush, Phillipe Pinel and William Tuke. Perhaps they were the natural result of the social forces of the last quarter of the 18th century. It has been pointed out by historians and sociologists that the American and French Revolutions with their resulting social and political changes and the Industrial Revolution with its effect upon economic and social life greatly influenced the whole system of interpersonal relations. The spirit of humanitarian treatment of individuals and the growing consideration of their rights as human beings characterized the period. The contributions of these three men who channeled these social forces into greater solicitude for the mentally ill were in some respects quite different in their nature. We are all familiar with how in releasing the patients in Bicêtre from their chains Pinel answered his own question, "Does not the mentally deranged need to breathe pure and healthy air?" In this act and in his dissatisfaction with the old-fashioned and irrational architecture of the mental hospitals he showed himself, one might say, an administrator in psychiatry. His interest in clinical psychiatry was well illustrated by his question, "How are we," he said, "to distinguish between the exasperation caused by the chains and the symptoms caused by the illness"?

As the first American physician to manifest an interest in psychiatry, Rush is deservedly known as the father of American psychiatry. His contributions, especially those in his most important work, "Medical Inquiries and Observations upon the Diseases of the Mind," were of extreme importance in the study of mental disease. Not for thirty years or more did any American psychiatrist attain his stature, although his favorite therapies —emetics, purgatives, bloodletting and intimidation—offered nothing that proved constructive.

Since he was not a physician the contribution of the third of this great triad, William Tuke, the first of the Tuke dynasty of four generations, was in providing more enlightened care for the mentally ill and not in the science of psychiatry. With his establishment of the York Retreat he demonstrated the important role of the hospital devoted solely to the care of the mentally ill with personnel specially trained for its task. He also demonstrated the effectiveness of moral and humanitarian treatment in contrast to restraint and punishment on the one hand, bloodletting and the all too liberal use of drugs on the other. Following the establishment of the York Retreat, and doubtless influenced to no small degree by it, hospital organization and hospital reform became one of the major interests of psychiatry. It was this new concept of a mental hospital that led to the establishment in America of such institutions as Friends Hospital, McLean Hospital, Bloomingdale, the Hartford Retreat and later Butler Hospital. Presumably, too, it influenced, directly or indirectly, the development of the mental branch of the Pennsylvania Hospital.

Probably it is not too much to assume that the solicitous and humanitarian attitude and the methods of treatment advocated at York plus the crusade of Dorothea Dix influenced the strikingly able physicians who had become superintendents of the asylums in the early 1840's to establish in 1844 the Association of Medical Superintendents of American Institutions for the Insane. Through change of name but without interruption of continuity this association has now become the American Psychiatric Association. The stated objectives of the new association were consultation and discussion of matters related to the conduct of institutions rather than the advancement of psychiatry. Perhaps on the whole their contributions to the science of psychiatry were not large. To be sure, Isaac Ray, one of the founders, had in 1838 published "Medical Jurisprudence of Insanity," the first treatment of the subject in United States. It ran through six editions, and nearly twenty years after its publication it was said, "It does more credit to America than aught in relation to insanity that has been produced." In spite of the fact that state hospital superintendents had done little or no research in the science of psychiatry, this branch of medicine in America remained largely in their hands for forty or more years. It was in the state hospitals nevertheless that research in psychiatry began. In 1868 a pathological laboratory was established at the Utica State Hospital, and in 1893, Adolf Meyer established a pathological laboratory in the Illinois Eastern Hospital for the Insane at Kankakee and began the most productive career which has been contributed by American psychiatry.

Medicine grew up under the apprentice system. The young doctor learned how to diagnose and treat illness by watching the experienced man with whom he was associated. What a contrast with

the instruction received in the present-day medical school! Apprenticeship has, however, been largely the training of the mental hospital superintendent even up to the present time. As long ago as 1938, Arthur Ruggles, speaking at a symposium on Mental Health conducted by the American Association for the Advancement of Science, expressed the opinion that, as with medicine, the apprenticeship method of training of a superintendent is an outmoded procedure and should be superseded by a more educational program. Ruggles called attention to the fact that national organizations interested in improved qualifications for the practice of psychiatry and neurology had established the American Board of Psychiatry and Neurology, which had set up educational standards and developed methods of examination to certify physicians in the clinical practice of these specialties. While he did not suggest the establishment of a special board for the certification of qualified mental hospital administrators, he did outline methods of formal administrative training to be pursued for two years by psychiatrists who had already become diplomates of the American Board of Psychiatry and Neurology. Doubtless it is a matter of much satisfaction to Dr. Ruggles, a former president of the American Psychiatric Association, that this organization has now established a committee on Certification of Mental Hospital Administrators. It is also developing plans whereby accredited training in hospital administration may be secured.

For many years the American Psychiatric Association was primarily an organization of administrators. Gradually, as was quite fitting, it became more and more a scientific society. That it still recognizes the importance of the administrator is demonstrated by the fact that it has now established the committee mentioned. It is the hope and expectation that certification as a qualified administrator by this committee will improve the professional qualifications and raise the status of the mental hospital administrator.

Because of his dramatic liberation of the inmates of the Bicêtre, Pinel became the symbol of the humanitarian treatment of the mentally ill. Perhaps, too, he should become a model for all mental hospital administrators, not only for his humanitarianism but for his vision, courage, initiative and his advocacy of many administrative procedures now used in many present mental hospitals. He recognized that the primary purpose of administration is to make available the most efficient means possible for the treatment and care of the patient. He realized what every mental hospital superintendent now recognizes: that the general therapy of patients and hospital management are inseparable. Unfortunately boards of trustees and central boards of control still occasionally fail to grasp this fact. In France the separation of administrative responsibility has, after many decades of trial, been abandoned. Assuming this premise that the therapy of patients and hospital management are inseparable, a great responsibility is placed upon the administrator. For many years the most important place of the administrator in psychiatry was that of the public—usually state—hospital superintendent. While there are now many other administrative positions that have acquired great importance this still remains one of much responsibility.

At first thought it may seem that the administrator's place in psychiatry may not call for his counsel and advice in the construction of a hospital for mental diseases. Such, however, is far from the case. The pioneer in America in developing construction of mental hospitals was, of course, Dr. Thomas S. Kirkbride. For over thirty years he was the acknowledged authority in this subject. That in addition to his contributions to hospital construction and hospital administration he had also a keen interest in psychiatry and in psychiatric instruction is shown by the resolution which he presented at the 1871 meeting of the American Psychiatric Association. "In every school conferring medical degrees," the resolution read, "there should be delivered by competent professors a complete course af lectures on insanity and on medical jurisprudence as connected with the disorders of the mind." The resolution also urged that these lectures be compulsory and accompanied by clinical instruction. The contributions of Kirkbride, who probably achieved a wider fame than did any other of the Original Thirteen, were by no means limited to construction and administration.

To return to the administrator with special reference to his function as director or guide in the construction of a public mental hospital. The designer of such an institution must know, of course, what means of study of the patient may be required both at the physiological and at the psychological levels. He must know, too, what kinds of treatment may be needed and therefore what facilities must be provided. The guidance of

the experienced administrative psychiatrist is therefore necessary from the first. Since every experience of the patient in the mental hospital may be therapeutic and constructive on the one hand or morbific on the other, the construction of a building for such patients should, so far as architectural arrangements are concerned, tend to promote influences and experiences that are therapeutic. We now believe, for example, that the interpersonal relation between patient and patient as well as the relation between patient and nurse may be of psychological significance. The administrative psychiatrist who is concerned with construction and accepts that the group may be a factor in treatment will provide, so far as is feasible, that patients be grouped in small numbers and according to age, personality, illness and treatment. He must impress upon the architect the fact that essentially the treatment of mental illness is the treatment of the individual patient and that his environment will not be such that the staff will feel frustrated in its attempt to treat the individual person. The therapeutically-minded administrator, and this characteristic is one of the most essential qualifications of the superintendent, will realize that modern intensive treatment requires a friendly, encouraging atmosphere with facilities that permit self-expression in work, recreation and relaxation.

The administrator, too, is the individual who determines whether the major interest of the hospital shall be professional or economic. Experience has clearly shown that the leadership of the institution must be professional. The administrator must, of course, operate within the limits of the budget received, yet through attitude and policy he can determine whether or not the emphasis shall be on therapy, teaching and research. If the latter objectives are the major ones and funds are judiciously expended for them, this fact is often recognized by the central board of control or appropriating agency, and budgets are gradually increased. The psychiatric administrator must not permit his interests to be diverted from the real purpose for which his institution was established. If he holds this objective constantly in mind and strives to make the experience of the younger physician an educational one, then professional performance of the staff will almost certainly be on a high level.

During a considerable number of years as an observer or as a participant in mental hospital administration, I have noted what I believe to have been a desirable trend in administrative policy. Administrative officers have become less authoritative, with the result that usually department heads show more initiative, develop a greater capacity for leadership and assume more responsibility. It is highly desirable that objectives be attained not so much by authoritative orders to others as by so influencing them that their own desires harmonize with those of the administrator. He should rule less and reign more. Department heads and others take over as their own the purposes of the leader. It is his task to integrate his assistants toward a common goal, to build a group animated by satisfying common purposes. He must convey qualities that will tend to weld all groups together. Among these qualities are enthusiasm, imagination and initiative. He should not only have the ability to visualize a plan which may take years to mature but also to apply the data of past experience and with discretion make use of the knowledge which the research and experience of others have made available. Since in public activities, particularly, there is a lag between the acquisition of knowledge and its practical application, courage and persistence are indispensable for the administrator.

The administrator's policies in the selection of his professional staff are of extreme importance. I am convinced that with rare exception the appointees should be young persons. To be sure, the present plan of organized psychiatric training, in which a young physician upon completion of his internship begins a definite program of specialized training, naturally results in the selection of young men for junior positions. Even in positions of greater responsibility relatively young men, if they possess plasticity of mind, are to be preferred. What is lacking in maturity of judgment is more than compensated for in creativeness. Long-continued service in the same institution is not always for the best interest of either individual or hospital. A reasonably rapid turnover of the professional staff is healthy. New blood should be injected into the organization if it is not to become static. The administrator, too, who has the reputation of placing his men in better positions will tend to attract young people. Not to promote men of long service when vacancies occur troubles the administrator and is frustrating to the individual whose seniority has not led to selection. To advance men into higher grades for the sole reason

that they have served a certain length of time is, however, poor administration and may lead to stagnation.

Having secured a desirable staff, the administrator must, as already suggested in the case of department heads, consider carefully the kind of organization under which his staff will work best. A staff does not function well in an atmosphere of autocratic dictatorship. The staff composed of young, relatively inexperienced physicians may create administrative problems that would not be present with a more experienced group, but the contributions which it makes to the hospital will outweigh these considerations. An attitude of autocratic dictation will result in a continuous disintegration of staff.

In certain important respects, there have been more significant changes in the training of the medical staff in the public mental hospital and in the objectives of its individual members during the past twenty years than in the preceding seventy-five. Prior to 1934 the training of the staff was, as has been indicated, largely by the apprentice method. A few members, perhaps irked by routine and by tradition, resigned to enter private practice. Rarely, on resignation, one combined private practice and teaching. There was no organized training in the study or in the treatment of mental disorders. Those physicians who were industrious, eager to learn and did so without direction and had an aptitude for administration received relatively rapid promotions in administrative responsibilities. For those lacking in incentive for personal and professional growth and those evasive of responsibility, promotions were slow. Not infrequently the administrative leader of the hospital partly through aptitude and partly through experience, became thoroughly competent in matters of hospital administration and saw that patients received excellent care and as much therapy as the more limited resources of the period permitted. Frequently, however, he had but limited knowledge of psychiatric literature and lagged in acquaintance with a developing dynamic psychiatry.

A hospital for mental disease is primarily an institution for treatment, but perhaps of almost equal importance it is a place for training and research. Because of its size the public mental hospital has abundant material for teaching, training and for research, preferably, perhaps, for clinical rather than for pure research. General medicine established the value of hospital training long before psychiatry became recognized as a medical discipline or psychiatric education along medical lines was attempted.

Since the establishment of the American Board of Psychiatry and Neurology in 1934, the situation in respect to the staff of the public mental hospital has undergone great changes and placed great responsibilities on the superintendent in the matter of providing training opportunities. No longer can a staff of young men be recruited as formerly, nor their training be left to their own devices and to apprentice methods. The superintendent who does not or cannot arrange for a formal and accredited training program for residents is hopelessly handicapped in securing a staff. The requirements of the American Board of Psychiatry and Neurology are therefore now providing the greatest stimulus for the instruction and training of young staff members ever experienced by the public mental hospitals. Unfortunately relatively few young psychiatrists who have passed the American Board examinations plan to remain associated with such hospitals indefinitely. For the most part they plan to follow private practice. They are prone to consider administration to be concerned merely with economic and disciplinary considerations and to believe that it is of little relevance or importance in clinical or scientific activities. As has been mentioned, it is hoped that the approaching opportunity for certification as a qualified mental hospital administrator will add to the attractiveness and prestige of administrative work.

Neither in matters concerning staff administration nor in other hospital departments will the administrator abrogate his authority, but he will be willing to discuss practices and policies and give respectful attention to suggestions. Because of their more intimate knowledge of the problems with which they are confronted, department heads, especially if they have been encouraged to assume responsibility, may have suggestions to increase efficiency of operation. They should be encouraged to solve problems at their own level. When the administrator closes his mind to the suggestions of assistants, he loses a valuable means of building morale and increasing loyalty. In general, the organization of his institution should not be too hierarchical.

A psychiatric administrator worthy to hold such a position will, of course, bear constantly in mind that the institution has only one justification for its existence—the treatment and care of the pa-

tient, the best treatment and care which the personnel of the hospital and the budget alloted to him will permit. It is not difficult for members of the allied professions—the psychologist, the social worker, the nurse, the biochemist, the clergyman and the occupational therapist—to realize this. These can usually be fused into a team, be imbued with the idea and spirit of an end to which each is helping from his own particular angle and in the light of his own special skills and knowledge. If a spirit of what may be called co-operative competition exists among departments, efficiency is increased. Others—the businessman, the construction foreman, the chief engineer and the farm manager—may verbally acknowledge this fact but it is not always easy for them to see that the work they are doing is a contribution to the treatment. If the administrator commands the respect and confidence of these necessary lay groups, a loyalty engendered by constructive leadership on his part, and a loyalty toward them based on their abilities and their willingness and desire to follow his policies, every administrative process will be recognized as serving the hospital's goal.

As has just been suggested, the mental hospital differs from other organizations in one very important respect. Every administrative act, every system set up, every method used in carrying out the purpose of the institution has a relatively profound effect upon the mental state of the patient. It is unquestionable that the administrative routine of the mental hospital plays a significant and important part in the progress of many patients. If this be true the administrator bears a special responsibility in relation to therapy. Practically all administrative policies have a potential or actual effect upon the mental state of the patient. The administrative service, therefore, has as one of its most important functions that of structuring the environment as a positive therapeutic agent. Doubtless Adolf Meyer had this in mind when he commented fifty years ago: "I am quite convinced that administrative duties deserve foremost attention." The general therapy of patients and hospital management are inseparable. The more nearly the hospital becomes an active living community, the more will its patients leave the institution. Hospitalization is no longer viewed as primarily a means of removing the patient from society or of keeping him busy in the hospital but as an opportunity to give him a sheltered milieu in which specific therapeutic experiences can be provided. These experiences will to no small degree depend upon the attitude of the hospital personnel toward him. This attitude will in turn be determined to no small extent by the institutional atmosphere created largely, and perhaps unwittingly, by the administrator.

The harmony which exists between hospital and patient may mean the difference between success and failure of treatment by the individual psychotherapist. If the psychiatrist comes to the patient as the representative of an institution which functions smoothly and with a minimum of friction, the rapport between its representative and the patient becomes stronger and more lasting. On the other hand, if the patient has been constantly irritated by tactless handling, exasperated by petty tyrannies and annoyed by inflexible rules enforced by poorly informed attendants and improperly trained nurses, he soon feels convinced that his welfare is not the first consideration. The attitude and quality of the nursing service is therefore a matter of great importance. Although the administrator may be hesitant to accept the responsibility for the attitude of the nursing and attendant personnel toward the patient, it is nevertheless his to a large degree. Thirty-five years ago Dr. William A. White, a superintendent who had a unique understanding of the troubled human personality and was also an administrator of rare sagacity, wrote: "An attitude on the part of the institution that sees in a restless irritability something to be repressed is not only unintelligent but invites a continuation of the very condition it is trying to do away with. It helps by the very repressive measures used to effect this end to create and continue that patient-institution disharmony upon which it is frequently based. In an institution dominated by the ideal of scientific knowledge, this ideal will so permeate the atmosphere and its effects will be so profound upon the staff, upon the employes, upon all in fact, that there will gradually grow out of such a standpoint a hospital finally and everlastingly free from the shackles of fear and ignorance, a hospital in which the patient will be received with an understanding attitude."

In organizing hospital procedures, one of the administrator's objectives should be to see that efforts are made to promote the patient's self-respect, sometimes characterized as the backbone of one's personality. For many reasons mental illness often involves the loss of self-esteem. Not only may this loss be a cause of mental illness

but it may also be the result. The unfortunate stigma still often attached to being in a mental institution may be communicated by thoughtless relatives, employes and friends, with the result that the patient may be deeply ashamed of his "nervous breakdown." Frequently one of the important tasks for the hospital is to aid the patient in re-building his self-respect. Essential to this is a gaining of the patient's confidence and trust, first in the personnel and ultimately in himself. As with the hospital's personnel, so with patients, the administrator's attitude should tend to one of selective permissiveness. Such an attitude may operate constructively and help to promote ego strength. It is desirable that the administrator shape his institutional policies so that the emphasis of the hospital should be more on health and less on fighting disease.

An extremely important duty to which the administrator should devote constant attention and in which he must secure the collaboration of all hospital personnel is that of promoting good public relations. This highly desirable attitude will usually follow if the public is treated with respectful consideration, with the little courtesies that promote good-will and if the patients receive the informed and solicitous attention which the professional status of physician and nurse presupposes. With regrettable frequency, however, the administrator has the unpleasant experience that after having assiduously sought to establish feelings of good-will and of confidence in the institution on the part of patients' families, a tactless assistant or employe may by ill-advised statements alienate these desirable attitudes. Expressed somewhat differently it may be said that one of the duties of the administrator is to seek to create a constant awareness of the value and meaning of the hospital to the community and vice versa.

Reference has just been made to the place of the administrator in the care and treatment of the institutionalized patient. Another place in which the psychiatric administrator may exert a profound influence upon both institutional and community psychiatry is in determining policies in the office of a central board of control to which state functions relating to mental health are assigned. The type of organization of that office and the authority given to a psychiatrist holding official position in it vary greatly from state to state. In recent years there has been a gratifying tendency to establish a department co-ordinate with other major departments in the organization of a state government. In some cases functions concerned with mental health are centralized in one of several bureaus, all of which operate under a department concerned with various public welfare activities. There are also numerous other ways of organizing these functions. It is pretty generally agreed, however, that in the larger states, at least, the state mental hospitals are most efficiently managed and mental hygiene education and activities best organized when there is a special department of mental health directed by a psychiatrist who has had long and varied administrative experience. In certain states, notably Massachusetts and New York, the central board of control uses its office as an agency for training selected senior physicians for administrative positions.

In many states the administrative code provides not only for a central board of control but also for boards of trustees for individual hospitals. The degree of authority delegated to these boards varies. In some states these boards have wide administrative authority while in others they are merely boards of visitors whose authority is largely limited to inspection and the submitting of recommendations to the central office. These boards represent the community from which the hospital draws its patients. Members of these boards are usually appointed by the governor. Some are selected because of their known interest in health and community welfare. In other cases the appointments may represent the payment of political debts. In either case the appointees have rarely had any experience in mental hospital administration and no special knowledge of the problem of mental disease. In that case the administrator in the matter of educating the board is confronted with both a challenging opportunity and a personal responsibility. If this task is adequately met, the administrator will have valuable coadjutors in interpreting the hospital to the community and in protecting it from possible political exploitation.

Perhaps it is permissible to indulge in a few scattered reflections concerning the public mental hospital administrator. Except for the teacher of psychiatry (and the latter operates in a somewhat different field) there is perhaps no one whose total contribution, direct or indirect, to psychiatry is potentially greater than that of such a person. His acts and his policies may profoundly influence the part which many hundreds of persons become able to play in life and what these persons come

to mean in the homes and lives of their families. The administrator cannot think of his position as a job but as one in which he has been entrusted with critical responsibilities, and that the manner and skill with which he discharges these may most intimately and extensively touch the lives of many persons. He should not permit a mass of administrative details to cloud his social consciousness and cause him to forget that the maladjustments to which we apply the term mental disease constitute one of many major social problems which should be studied from the standpoints of many disciplines. Psychiatry is not only a medical specialty but in various ways touches many departments of thought and experience.

To such an extent as is possible, the administrator creates, provides and maintains a physical and psycho-social environment which should as nearly as possible approximate home and community life. He encourages personal intercommunication with its frequent contribution in facilitating recovery and the eventual re-integration of the patient in society. The administrator should look upon the institution as a therapeutic community. While he recognizes its limitations in that respect, yet he should realize that there are many resources of therapy that are not fully obvious and that he should make all the various professional and subprofessional staff aware of these. While he must recognize the realities of institutional functioning, yet he should radiate a philosophy of optimism. He will make his personnel conscious of the fact that the existence of some rules is a necessity in any form of life, yet he must not make the institution a rule-ridden one having a master formula for everything. If the aim is one of conformity, there is a loss of individual initiative. There should be a flexible basis for recognition and encouragement. In the public mental hospital one may, as in so many other places, find lethargy or even intransigence to change. Sometimes this can be met by efforts to raise the confidence level in personal competence and by remembering that the acceptance of policy changes requires not only an intellectual but an emotional understanding. Perhaps some must be reminded that the hospital is not a business, the purpose of which is self-perpetuation, but that its product consists of human beings who have found new reservoirs of strength to face the stresses and to enjoy the pleasures of living.

Above all the administrator must remember that the institution will be the lengthened shadow of his own personality. More than any other one factor this will determine the atmosphere of the hospital. Perhaps this is why one sociologist, not a physician, yet intimately acquainted with mental hospitals through an unusually close association with many, spoke of some hospitals as being repressive, others as regressive, others as creative, and others, unfortunately, as paranoid. Partnership of administrator and personnel should be one of the aims of mental hospital management. Loyalty cannot be engendered by fear or by dictatorship but only through mutual loyalty and on mutual belief in abilities.

To return to discussion more relevant to the place of the administrator, especially the mental hospital administrator, in psychiatry—to a large, perhaps even to a major, extent the function of the administrator is to provide the environment, the organization, the equipment and the administrative procedures that promote the welfare and recovery of the patient. Most important of all, he must provide such professionally trained personnel as will understand emotionally sick personalities and by appropriate techniques, including psychological ones, bring such relief to the patient's emotional problems and disorders as will permit him to be a happy, mature and independent person.

Perhaps these very discursive remarks may be concluded by the statement that the administrator has fulfilled his function if he has provided conditions that will enable patients on leaving a mental hospital to reply as did a certain woman. This former patient, after complete recovery from a protracted mental illness, was asked what had helped her so much in the hospital. Her answer consisted of two words: "They understood."

With ovarian cancer, the first intimation of trouble is likely to be the presence of a lower abdominal mass with no pain or bleeding.

* * *

In the study of the common cystic and solid carcinomas of the ovary, not enough attention has been paid to the histologic grading which has been a useful, though not infallible, prognostic aid with malignant tumors in general.

* * *

The incidence of prostatic cancer at autopsy in men over fifty years of age is approximately 24 per cent.

An Evaluation of Changes in Test Behavior Following Psychosurgery

By John A. Larson, M.D., Leslie R. Witsaman, Ph.D., and S. B. Mitsos, M.S.
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THIS report summarizes some of the results of a continuing study on the effects of lobotomy as measured by certain psychological tests. This research is not completed, but it is felt that some of the trends evident in the data are interesting and merit reporting.*

The procedure utilized in gathering the data was as follows: Patients were tested just prior to undergoing psychosurgery and tested again at three months, six months, and one-year intervals following the operation. The psychological tests used were the Wechsler-Bellevue Intelligence Scale for Adolescents and Adults, Rorschach Ink Blot Test, Bender-Gestalt, Draw-A-Person, and the Seguin Form Board, II. Each of these tests was given to each patient prior to and at each of the intervals following surgery.

Although testing was attempted on a great number of patients, it must be noted that many of these were inaccessable prior to the operation or their performance was so poor that it made objective scoring impossible. Such patients had to be dropped from the study.

Analysis of Data

For purposes of analysis it was decided best to report each test separately. Table I presents the quantitative data for all tests. Since there were virtually no patients for whom all four protocols were complete, the report is limited to the pre-surgery, three- and six-months post-surgery tests.

Wechsler-Bellevue Intelligence Scale.—Wechsler-Bellevue data are available on a group of patients who were tested prior to surgery and at the three-month and six-month postoperative intervals. The table illustrates changes in Full Scale, Verbal Scale and Performance Scale I.Q.

An interesting trend is manifested here in that there is an increase in Full Scale I.Q. from the preoperative test to the six-month postoperative test. This increase is due to an increase in Performance Scale. There is actually a decrease in the Verbal Scale I.Q. in this time interval, although this decrease is only a matter of 3 I.Q. points. The increase on the Performance Scale is 9 points and may be attributed to practice or learning.

Rorschach Ink Blot Test.—The Rorschach was administered and scored according to the method outlined by Beck. On this test there is a continuous but small decrease in R, the total number of responses. There do not seem to be any appreciable changes in any of the Rorschach scoring categories. Even the F + %, which may be interpreted as a measure of reality contact, is not evidenced as changing.

Draw-a-Person Test.—The Draw-a-Person Test consists, very simply of having the patient draw a human figure of each sex. Its purpose is that of yielding information concerning personality and adjustment.

In order to evaluate the test objectively, three experienced clinicians rated the three drawings of each patient (preoperative, three-months post, and six-months post) on a three-point scale. A rating of 1 indicated poorest adjustment as reflected by the drawing and a rating of three reflected best adjustment. The judges did not know the order of the tests, the dates administered, or the names of the patients.

Inspection of the mean ratings presented in Table I indicates a moderate, but consistent trend toward better adjustment, as viewed by the judges, in the postoperative drawings. This trend is present in both the drawings of the male and the female figure.

Bender-Gestalt.—This measuring device consists of copying certain standard geometric forms such as circles, squares, diamonds, et cetera. The data were evaluated in the same manner as the Draw-a-Person using three-point ratings made by three expert judges with the same conditions of anonymity applying to the drawings. Here again is found a moderate, consistent trend toward better adjustment, as viewed by the judges, in the post-operative drawings.

From the Logansport State Hospital, Logansport, Indiana.

*The test protocols on which this report is based were gathered at Logansport State Hospital from 1949 to 1953.

TABLE I. SUMMARY OF QUANTIFIABLE TEST INDICES

	Pre	Test Intervals 3 month	6 month
1. Wechsler-Bellevue (N-12)			
A. Full Scale I.Q.	92.2	92.0	97.4
B. Verbal Scale I.Q.	99.5	92.8	96.7
C. Performance Scale I.Q.	89.3	92.2	98.1
D. Sub-Tests			
1. Information	9.25	8.67	8.75
2. Comprehension	6.92	5.83	6.67
3. Digit Span	7.50	6.00	6.92
4. Arithmetic	7.17	7.08	8.50
5. Similarities	7.50	8.08	9.08
6. Vocabulary	10.00	9.25	9.08
7. Picture Arrangement	5.67	4.17	6.50
8. Picture Completion	6.50	6.33	7.25
9. Object Assembly	6.83	9.75	10.25
10. Block Design	6.83	7.42	7.75
11. Digit Symbol	4.83	5.42	6.17
2. Rorschach (N-14)			
A. R (total no. responses)	17.93	16.79	15.70
B. W% (% whole responses)	27%	33%	32%
C. D% (% large detail resp.)	67%	57%	58%
D. Sum C (sum color resp.)	3.32	2.04	2.11
E. M (human movement)	1.93	1.79	1.43
F. F + % (good form %)	62%	72%	66%
G. Sum T (sum texture resp.)	.61	1.07	.75
H. Sum Y (sum shading resp.)	1.18	1.07	.86
I. H (human resp.)	3.43	3.36	2.57
J. A (animal resp.)	7.86	8.00	8.36
3. Draw a Person (N-16)			
A. Female	1.62	1.98	2.39
B. Male	1.77	1.96	2.27
4. Bender-Gestalt (N-18)	1.59	2.01	2.38
5. Seguin Form Board (N-11)			
A. Mean time of fastest trial	26.91 sec.	23.09 sec.	21.45 sec.
B. Mean range between fastest and slowest trial	30.00 sec.	19.18 sec.	7.91 sec.

Seguin Form Board, II.—This test consists of placing a number of wood blocks of various sizes and shapes into their corresponding holes in a board. Three trials were given and time was recorded for each trial. This is one of the more common tests of visual-motor co-ordination.

Two methods of analysis were used with the Seguin Form Board data. Both are presented in Table I. First, the time in seconds of the fastest trial for each subject at each test interval was recorded. Then the mean for each interval was computed and recorded in the table.

The second method of anaylsis involved the recording of the difference between the fastest and the slowest time for each subject at each testing interval. The means of these differences were computed and are also reported in the table.

These data are among the most striking herein reported. There is a consistent decrease in mean time which is only moderate. However, the mean range—or variability—shows a substantial decline. This seems to indicate that although the decrease in time is only slight, there is a substantial increase in efficiency of performance on this task.

Discussion

On the basis of the test data we can draw the following conclusions about this group of patients:

1. There seems to be a few gross changes reflected in the measuring devices used following lobotomy.

2. In those cases where changes are manifested, such changes may be due to factors other than surgery, such as practice.

3. At a qualitative level, however, experienced clinicians seem to be able to discern an improvement in adjustment level in this group of post-lobotomy patients.

The difficulties of design and execution of research studies regarding the psychological changes concommitant with frontal lobe surgery are recognized in the study here reported. Certainly, the significance of test indices remains vague in the absence of a well-defined group of control subjects. The results have stimulated a re-appraisal of procedure and research design, and a further study is being undertaken which will utilize an improved test battery, a control group of subjects, and a more objective procedure for the gathering and recording of test and behavioral data.

To the degree that the projected study meets the often enumerated, but seldom fulfilled, scientific criteria applicable to such investigations, the measurement of changes following lobotomy will be accomplished.

The initial symptom in tumor of the testes is almost always a painless swelling of the testis accompanied by a sense of weight in the scrotum.

* * *

Every mass in the scrotum should be considered malignant until proved otherwise.

On bimanual palpation, a malignant tumor of the testicle feels heavier than other masses.

* * *

Orchiectomy, with resection of the spermatic cord, spermatic vessels and retroperitoneal lymph nodes should be carried out for all malignant tumors of the testis, a cure is anticipated.

Periodic Health Appraisal

Oral Cancer

By B. E. Luck, D.D.S.
Lansing, Michigan

NO CAVITY of the body is as accessible to complete examination as the oral cavity. Visual, digital, and roentgenographic examinations are readily performed. Examination of the stomach, rectum, bladder, and the uterus is much more difficult and requires specialized techniques.

Considering this, one might logically conclude that oral cancer should be detected earlier and therefore be more readily controlled than cancer occurring elsewhere. Unfortunately, many cases of oral cancer are seen late. Early recognition is the responsibility not only of the patient but of the dentist and the physician. The oral cavity and the tissues which are involved in its make up have long been a "no man's land." To the physician the mouth too frequently is a cavity through which he observes the tonsils and the throat. To many dentists the mouth is largely the gateway to the teeth and the jaws.

Cancer in the oral cavity is so favorably located for an early diagnosis that the condition may even be suspected by the informed patient. Such a diagnosis, however, must be confirmed by microscopic study of the biopsy specimen by a qualified pathologist. In such cases the dentist is in a unique position of being able to diagnose oral cancer even earlier than the physician for dental or oral problems brings the patient to him sooner than he would have occasion to visit his physician.

An examination of the oral cavity by either the physician or the dentist should be complete in every detail including extraoral regional examination since cancer of the oral cavity, like other cancer, tends to spread and metastatic masses may be found, most frequently in the submental, submaxillary and lower cervical regions. In a recent study in the state of Connecticut, metastases to the neck were noted on the first examination of 36 per cent of patients having head and neck cancer. Less than 5 per cent of oral cancer spreads below the clavicle. The presence of nodular masses or tumors in the neck is an immediate indication for a search for the primary lesion in the oral cavity or face.

A proper oral examination, both extraoral and intraoral, should proceed according to the following systematic sequence in order to assure completeness:

Extraoral Examination

1. Face.
2. Parotid and submaxillary salivary glands.
3. Submaxillary and submental lymph nodes.
4. Jaws and tempormanibular joints.
5. Neck and cervical lymph nodes.
6. Lips and corners of the mouth.

Intraoral Examination

1. Mucous membranes of lips and cheeks and papillae of the parotid ducts.
2. Floor of the mouth, sublingual gland and submaxillary duct.
3. Tongue, all surfaces.
4. Palate (hard and soft).
5. Tonsils and tonsillar pillars.
6. Posterior pharyngeal wall.
7. Retromolar area.
8. Gingiva and alveolar bone, peridontal pockets, and interdental areas.
9. Teeth.

Danger Signals of Oral and Facial Cancer

With few exceptions there is no pain at the beginning of any cancer. By the time the pain is evident the growth is usually far advanced. There are a few signals which may indicate the possibility of a cancerous growth which we should have in mind. They are as follows:

1. Any painless lump or thickening.
2. Any sore that does not heal and remain healed after two to three weeks.
3. Progressive changes in the color or the size of a wart, mole or birthmark.
4. Chronic progressive thickening of either the lips or oral mucosa.
5. Bleeding or discharge.
6. Swelling of the jaws, asymmetry of the face.
7. Difficulty in opening the mouth.
8. Sudden appearance of a swelling of the neck.
9. Difficulty in swallowing, persistent hoarseness or unexplained cough.

These signs indicate that something is wrong. It might be cancer.

(Continued on Page 976)

Editorial

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION
Civic Auditorium—Pantlind Hotel, Grand Rapids
Wednesday-Thursday-Friday, September 28, 29, 30, 1955
YOU are invited to attend the Ninetieth

INDUSTRIAL MEDICINE

MICHIGAN is a highly industrialized state, and with the projected increase in population we may expect that there will be a comparable increase in manufacturing. If the pattern of the past is followed, this increase will be predominately in small plants which obtain their medical service from physicians in private practice. Unless there is a reversal of form, first aid and treatment of injuries will be the only attention small plants will receive.

There appears to be no other field of medicine that has been given so little consideration by the medical profession as the well-rounded preventive program for small plants. Regardless of the reasons why physicians have shown so little interest in industrial health, the situation can be improved. Many plants are openly receptive to more complete medical service. It is with this in mind that the Committee on Industrial Health of the Michigan State Medical Society has asked its members, in co-operation with the Councilors, to stimulate interest in this field throughout the state. The devoting of this issue to the subject is for the same purpose.

Industrial health service in small plants can fulfill all of the purposes to promote the health and physical well-being of employes. According to the Council on Industrial Health, these objectives should be accomplished by (1) prevention of disease or injury in industry by establishing proper medical supervision over industrial materials, processes, environments and workers; (2) health conservation of workers through physical supervision and education; (3) medical and surgical care to restore health and earning capacity as promptly as possible following industrial accident or disease.

Certification of industrial physicians as specialists is an accomplished fact. There is a section on "Occupational Medicine" within the American Board of Preventive Medicine. These developments will interest younger physicians in this field in the future, but the present demands must be met by those now in practice.

As great as the need is for physicians to render more preventive medicine to industry, the public relations value cannot be overlooked. By becoming acquainted with problems of placing and utilization of personnel to the greatest benefit for the worker and production, there will be better understanding between industry and the medical profession. As a result, the labor force as well as management will be enlisted on the positive side of the public relations program MSMS has been putting into effect.

MEDICINE AND PSYCHIATRY

THE ever-widening horizon in the study and treatment of mental illness has focused public attention upon the psychiatrist. This publicity is a mixed blessing and has resulted in much confusion in terminology in newspapers, magazines, and television programs. The most important area of confusion appears to be in the professional titles of those persons working primarily in the field of mental illness. This applies particularly to the limitations of activity imposed by the professional training of ancillary personnel in the field. Controversy and complication develop as a result of those attracted to this field, who are medically untrained.

Recently, a national news service carried a statement, "Three psychologists were appointed by the Court to examine the 'accused.'" In a newspaper story, a psychologist well known in educational circles was called a "child psychiatrist." Frequently, a person who is referred to a psychiatrist for treatment of an illness objects to this referral with some such statement as, "I need a medical doctor—someone who can write prescriptions." Occasionally, a patient with a serious men-

(Continued on Page 972)

The Annual Session

Another year of progress of the Michigan State Medical Society will be completed at the Annual Session in Grand Rapids, September 25-30, 1955. The location of this meeting again provides a convenient meeting place accessible to the membership, especially those in the western and northern counties.

As usual, The Council meets Sunday, the day before the House of Delegates assembles for its annual business session (Monday-Tuesday). The Council, at this meeting, reviews last minute committee reports and prepares its supplementary annual report for the House of Delegates.

On Monday, the House of Delegates opens its annual session. The business conducted by the Delegates should be of prime importance to our entire membership. Officers, Councilors and AMA Delegates elected by the House constitute our official leadership for the coming year. Our Delegates, representing the membership of the various counties, provide the truly democratic representation in the affairs of our Society.

The House, by resolution and debate, will decide the policies of our Society. All Delegates are urged to report back to our componet societies the decisions reached at this annual session.

Following the two-day meeting of the Delegates, the profession is then offered a great postgraduate opportunity. Three days of scientific sessions, covering a variety of topics, are presented and discussed by outstanding medical leaders of national repute.

Doctor, how can you pass up this opportunity? Can you afford to stay home and deprive yourself of this stimulating presentation of current medical progress? Your patients will not only grant you leave, but they expect you to keep up to date in the interest of better medical service.

Keep abreast—Keep alive—Attend MSMS in '55!

President's

Message

Robert H. Baker

President, Michigan State Medical Society

MEDICINE AND PSYCHIATRY

(Continued from Page 970)

tal illness seeks help from the "marriage counselor" instead of from the psychiatrist, and this on the recommendation of his lawyer or even his family physician. Treatment of psychosomatic disease or of psychogenic symptoms by the psychiatrist may be misunderstood or criticized by his own medical colleagues.

It is important for the medical profession to undertake a program of better public education. The medical profession should take the initiative rather than permit the only avenue of information to be through the medium of television, newspapers and magazine articles. We, as physicians, need to know the capabilities as well as the limitations of our non-medical professional confreres (psychologists, social workers, counselors, et cetera) who are extremely helpful in the field of mental health if they work under the supervision and guidance of the psychiatrist.

The public should have a better knowledge of the training and capability of the qualified psychiatrist. The psychiatrist, like any other physician, is trained in scientific medicine. He must satisfactorily complete a full medical course and a rotating internship in a recognized hospital. His specialty training requires three years of approved residency in a recognized training hospital and an additional two years of experience limited to the practice of medicine in the field of psychiatry before he is qualified to take the certifying examination as a specialist. This basic training must include physiology and pathology of the central nervous system as well as the study of psychology and psychotherapy. The use of such physiological treatments as insulin, electroshock, and many of the new drugs by the psychiatrist requires much more than a superficial knowledge of general medicine. The numerous advances in medicine require that the psychiatrist serve in his capacity as a physician, especially in his readiness to recognize the signs and symptoms of any disease process. Psychiatric research is closely integrated with physiological and pathological studies. The medical educator is keenly aware of need for comprehensive medical training. It is the responsibility of the physician to help his patients to understand the importance of the psychiatrist who is medically trained in the treatment of mental illness. The wise practitioner of medicine will observe and alert his colleagues and patients to the dangers of the nonmedical approach to a serious medical problem—mental illness.

RAY W. WAGGONER, M.D.

DOCTORS' SURPLUS MONEY

WORKING on the theory that doctors are likely to have some surplus money, almost every special interest tries to help him spend it. Chambers of Commerce in many of our cities urge their members to make no contributions except after a complete survey to be sure the project is really worthy.

The medical profession has its peculiar demands and should have certain individual determination to assure that our donations are rightly placed where we know the need is justifiable. For years, Michigan doctors of medicine have generally recognized certain outlets for the money they may donate. Many years ago, the doctors of Michigan established the Michigan Foundation for Medical and Health Education, Inc., and many gifts were made—some in large amounts, others very modest, all well received and all well used. Lately, the Foundation has been loaning money to students who apply. Since G.I. aid appears to be about ended, there is need for more available money which can be distributed to students needing help.

In a recent editorial, we commented on the suggestion of William LeFevre, M.D., Councilor of the Tenth District, that we each recognize an obligation to help in this worthy cause, and give a "ten spot" on our birthday. If each of our 5800 doctor members would do so, quite a sum might be used in educating at least a dozen other doctors for rural service. Earl I. Carr, M.D., of Lansing, President of the Foundation, told the Editor that the Foundation could also handle sums given for specific purposes; for instance, memorials for special research for cancer, tuberculosis, multiple sclerosis, the money being added to sums now available in the nature of augmented help for students who are doing such research.

Another Michigan interest is the completion of the Beaumont Memorial on Mackinac Island. The old American Fur Company building has been restored, the original foundation still being part of the building. The Michigan State Medical Society has completed the restoration and placed it in the custody of the Mackinac Island State Park Commission. We are all proud of what we have

accomplished, but there is still about $10,000 to be gathered to make final payment of the costs. Many of our members have given once, some of them estimating what the proportional amount would be for each member and giving that amount, but not enough to cover those not giving. We are short, and wish every member would again subscribe a little so the project can be paid for, and so as many names as possible, preferably all, be inscribed on the rolls.

Other Objectives

We have listed two of our Michigan projects worthy of support whenever our individual members can spare a few dollars to further a good cause. There are also two activities of the American Medical Association. First is the American Medical Education Foundation. We have seen the willingness of our federal government to acquire control over many activities on the national level, which soon become so nationalized that the independent nature is forgotten. We are especially fearful of the field of medical education. The Supreme Court, in a famous case, ruled that whatever the Government subsidizes, it may control. For many years, the medical schools have been struggling to expand, meet the demand for more doctors, give improved educational advantages, and expand the teaching staff. These all cost immense sums of money, many times what the students pay in tuition. Most of our medical schools are supported by the states or cities and find additional money limited. A long time ago, intimation was made that subsidies might be available from the federal government. The American Medical Association, fearful of ulterior results, has urged our medical men to contribute to their Alma Maters as a gesture of loyalty, a means to conserve the job of medical education as private enterprise, and a repayment of obligations inherent in their partially donated medical training.

It has been estimated that about thirty dollars a year from each doctor would not be an unreasonable burden, but would place the medical schools on an independent and well-equipped plane of operations. Why not accept this added responsibility? Our medical schools have provided our own education, can we not reciprocate?

Much effort has been made to counter the efforts of the World Health Organization of the International Labor Organization which is a socialistic group receiving support from the United States Government, but actively promoting the establishment of socialized medicine throughout the world. The American Medical Association has consistently opposed that concept.

The World Medical Association was organized through the AMA and has spread very satisfactorily about the world. There is an American Committee or group working with the world group, sponsored by the American Medical Association. Every Doctor of Medicine is privileged to join. The fee is ten dollars, and can be sent direct to the Executive Secretary, Louis J. Bauer, M.D., Hampton, N. Y., or through the headquarters of the AMA at 535 N. Dearborn, Chicago.

We have invited to the attention of our members four worthwhile causes which, in all, could be covered by sixty dollars, just about the amount the automobile labor unions have been collecting from every one of their members in preparing for a strike to enforce their demands. Think it over—the unions, being prepared, have won their objective with not too severe a struggle. Were we prepared in the same manner, the medical profession could do many works of good, here in Michigan, and throughout the nation and the world. These gifts are remarkably small, considering the tremendous import.

AN EVALUATION

NEARLY 50 per cent of the members of the Michigan State Medical Society have entered the private and independent practice of medicine within the past twenty years. They have no personal knowledge of the problems and difficulties in the practice preceding that time. We were just emerging from a period of post-World War I depression, with empty offices, long hours, every day, evenings and Sundays—so as not to miss a single call. Years were needed to build a stable and livable practice.

That was followed by the great depression of the thirties—years which tried men's souls. Never before had the Federal Government taken over the relief problems. We saw fabricated work, men raking weeds and then raking them back, digging, road building. Men with no regular work were set at something and being paid $16.00 a week as an established minimum, but adequate wage upon which they were to support their families. Those who had regular jobs got very little more.

Doctors were glad to take care of every patient

who called them, hoping to get some pay from the more fortunate souls, and relief doles for the others. Patients needing hospitalization never had money left for the doctor. These days of stress and uncertainty lead inevitably to the solution the world awaited, the non-profit, hospital and medical plans. Our far-seeing leaders begged the insurance companies for help, but were told medical and hospital care was uninsurable. Being unconvinced, our medical pioneers established our own plans and made them work. Nature seems always to have a solution for each intolerable condition which develops. The Blue Cross and Blue Shield went far to re-establish the practice of medicine as a healthy avocation.

After fifteen years of depression—starvation wages accepted as adequate for the support of families, our Service plans for families earning up to $2500 a year were luxury. The practice of medicine came out victorious over its doldrums. The days of 50 per cent and at most 70 per cent collections, and the doctor considering himself fortunate, were passing. Insurance was paying increasingly larger percentage of our patients' bills and with no collection effort.

A CHALLENGE

CURRENTLY, every doctor who wishes to be is busy, and his patients are in general very considerate of his spare hours. From 60 to 70 per cent of the people have some form of insurance which pays the most part of their medical and hospital costs. Blue Cross and Blue Shield, alone, cover half of our Michigan patients—we should be and are thankful, but a new prospect faces us, a change is in store.

Every member recently received a letter from Robert L. Novy, M.D., President of Michigan Medical Service, outlining the new contracts with the large automobile industries' employes. Other industries will surely follow. These contracts were demanded as a part of the recent guaranteed annual wage settlements, and call for a $6,000 ceiling of complete coverage—"full payment." Our members must follow through, and make the contracts work. They are now on trial. The business will go to the commercial companies, if our service is not according to the book. We have no control over such companies, and their allowances for service will be determined by their actuaries.

Our time of trial is before us. We can continue the glorious progress we have made, or we can wreck the whole structure by alienating the automobile industry and probably also the steel industry. We thoroughly believe that the doctors should accept the new rates as full payment. New rates must necessarily be established, and they should be adequate. Organized labor will raise no question, because industry is expected to foot the bill.

The new schedules must not price us out of business. The smaller concerns must also use these plans and will have to pay the premiums out of limited profits. We are definitely in a squeeze. If we do not co-operate in this new concept, we could conceivably return to the regimen of the older times before insurance. Fifteen to twenty years ago, the medical profession solved our problems to satisfaction, and we can do it again. We believe the coming problems just as significant—it's up to us!

NEW COUNCILLOR

G. THOMAS McKEAN, M.D., Detroit, has been appointed by the President and confirmed by the Executive Council to fill the vacancy on The Council caused by the resignation of W. D. Barrett, M.D., Detroit. Dr. McKean was born in Detroit in 1908, received his A.B. degree from the University of Michigan, and his M.D. from Harvard Medical School. Internship and residency training were received at Boston City Hospital and University Hospital, Ann Arbor. He was licensed in 1936, and was certified by the American Board of Internal Medicine in 1942.

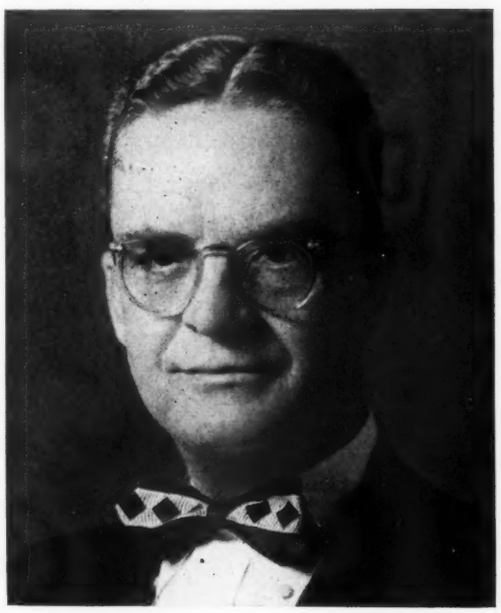
Dr. McKean is Clinical Associate Professor of Medicine, Wayne University College of Medicine; attending consultant, Dearborn Veterans Administration and Herman Kiefer Hospitals; staff member, Harper and Receiving Hospitals, Detroit.

From 1948-1950, he was Secretary of the Wayne County Medical Society, in 1949, Chairman of the Medical Section, Michigan State Medical Society, and in 1950, he was appointed to the Michigan State Sanitorium Commission. He is a Fellow of the American Medical Association and the American College of Physicians, a member of Wayne County Medical Society, Michigan State Medical Society, American Trudeau Society, Detroit Academy of Medicine, Detroit Surgical Association, and Detroit Medical Club.

George J. Curry, M. D.

An Incomprehensible Enigma

George J. Curry, M.D., is an enigma even to those who know him best. His is an elusive personality deeply imbedded with principles and tradition, and he is as unpredictable as the March wind. When one begins to feel that he knows George Curry, he suddenly discovers a stranger. He is dynamic and intensely aggressive, yet paradoxically mellow with a wealth of sentimentality.



George was reared in Michigan's Upper Peninsula by his grandmother. Although she was pitiably poor, she possessed boundless philosophical riches. It was from her that he inherited and developed those traits of character which a male must possess in order to be a man.

His early education was made possible by working at odd jobs and later in the iron mines.

He developed a strong love for music. At fifteen he was so proficient with the trumpet that he was known as "The Boy Wonder" of the Upper Peninsula. He was sent to Chicago where he auditioned for John Philip Sousa. Because of his youth, however, the eminent musician advised him to resume his studies rather than proceed with a musical career. He still maintains a strong love for music. Given a good pianist or a barber shop quartet he can listen to his favorite songs for hours. Until a few years ago he sang as a member of a quartet called "The Four Horsemen."

His trumpet supported him through the University of Michigan Medical School. After graduation he interned and received his general surgical training at Long Island College Hospital, Brooklyn, New York.

George Curry's interest in the surgery of trauma began many years ago when he felt that the management of the injured person, particularly those with fractures, left much to be desired. Since then he has been intensely interested in improving the care of the injured.

Over twenty years ago he organized the Section for the Surgery of Trauma at Hurley Hospital in Flint. This Section has gradually expanded so that at present it is the second largest in the state and has attained national recognition. Under his direction as Chief of the Section, it is effectively utilized for teaching.

One of his finest contributions to the care of the injured resulted from his interest in their transportation. This arose when he saw accident victims carted to the hospital without splints and with dangling fractured extremities. With relentless vigor and with the enthusiastic direct assistance of George A. Hays, M.D., City Health Commissioner, he sought and obtained an ordinance requiring ambulance attendants to be certified as to their proficiency. Administration of the ordinance is enforced by the City Health Commissioner. Specialized instruction is given by the local Red Cross. A dramatic improvement has resulted. The *Saturday Evening Post* will publish this story in a forthcoming issue.

George Curry is a member of the American College of Surgeons and has been active in its affairs for many years. He is now serving his third term as a member of the Board of Governors and was recently elected president of the State Chapter.

He has been influential with various committees on trauma of the American College of Surgeons for two decades. He has been Chairman of the Flint and State committees on trauma and Chief

of Section Five which includes Ontario, Michigan, Ohio, and Kentucky.

Six years ago he was made a member of the National Committee on Trauma of the American College of Surgeons. He is now Chairman of the Subcommittee for Regional Committees on Trauma of the United States and Canada. He is also Chairman of the National Subcommittee on Transportation of the Injured.

He is a founder member of the Central Surgical Association, a founder member and Past President of the Flint Academy of Surgery, and he belongs to the American Association for the Surgery of Trauma and the Detroit Academy of Surgery.

He has published many articles and devised several surgical instruments and appliances.

For many years George Curry has had a dream concerning Hurley Hospital and graduate medical education. He felt that graduate medical education should be decentralized because of the many opportunities for this type of training in hospitals other than large teaching centers. It was through his sustained efforts in co-operation with the University of Michigan Medical School that an approved residency for the training of young surgeons was established at Hurley Hospital ten years ago. This not only produced well-trained surgeons but also elevated the quality of patient care. He has been Chairman of the Committee of Graduate Training in Surgery since its inception at Hurley Hospital.

George Curry is an inspiration to many who have known him. Because of his enthusiasm, which is both chronic and contagious, he stimulates young men to learn the art and science of surgery. His genuine warmth and humility coupled with his intense aggressiveness endear him to the hearts of these young men.

He believes that one must know more than just science to earn the title "Surgeon." The mechanics and techniques of surgery can be learned rapidly and easily by any reasonably intelligent person, but the morals and ethics of surgery can only be acquired through a painfully prolonged process.

He states, "We do not train young surgeons. We merely create the opportunities and a state of inquiry by which they train themselves under organized supervision."

George Curry's teaching has emphasized more than just the techniques of surgery. He believes there are certain intangibles, those nebulous things in the human equation which are so difficult to describe, which make a good surgeon.

He has taught his residents about the educational hand. The thumb is the most important digit and stands for work. This makes up half of the value of the educational hand. The index finger stands for honesty without which the work would be worthless. As the index finger works with the thumb, so do work and honesty go hand in hand. The other three fingers which stand for loyalty, enthusiasm, and initiative complete his picture of the traits of a good surgeon.

Because of their contact with this man, the surgical residents at Hurley Hospital have founded The George J. Curry Surgical Society. This society is dedicated to preserve and promote the principles and ideals which he has instilled into the young men with whom he has come in contact.

He enjoys his home with his lovely wife, Ruth, and he has two charming daughters. Among his hobbies are golf, fishing, and gardening.

With all of these achievements George Curry still remains a mysterious, unpredictable person. There is a tool shed in his back yard which bears looking into.

—Sydney N. Lyttle, M.D.

ORAL CANCER

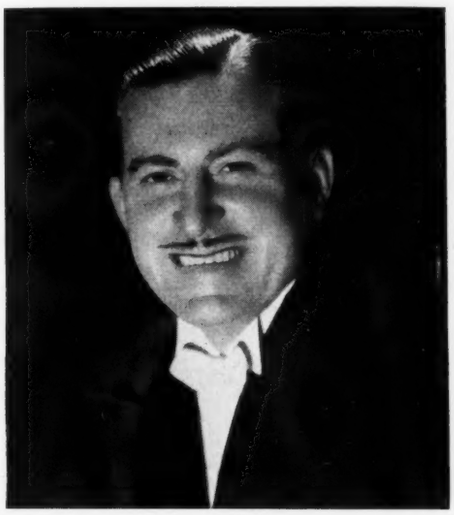
(Continued from Page 969)

I would be remiss if I did not take this opportunity to ask for a continuance of the co-operation which has existed between the two professions of dentistry and medicine. It has been said that the problem of treating and diagnosing cancer is the exclusive problem of the medical and dental professions. The dentist's knowledge of the oral cavity and the surrounding supporting tissues can be of inestimable value in the prevention of, the detection of, and in the treatment of these lesions. An interchange of knowledge will do much to reduce the mortality rate of this type of lesion.

Floor Show Entertainers — MSMS 90th Annual Session

State Society Night Pantlind Hotel - Grand Rapids September 29, 1955

MARVIS — A very lovely and talented girl accordionist.



CLARENCE SLOITER—a most novel and unusual comedy attraction recently presented in the Empire Room of Chicago's Palmer House with outstanding success. His interpretation of comedy magic act in which the magician is enjoying his "night out" results in many guffaws. This is an outstanding act.

SONNY MARS — Master of Ceremonies and Outstanding Comedian. In the style of Danny Thomas, he's always a big hit. Just closed Chicago Theater and has been featured on coast to coast television in the Comedy Hour.

TULARA LEE AND COMPANY—Man and girl hilarious comedy attraction in which comedy singing and comedy acrobatics are utilized to the enjoyment of the audience. Audience participation makes this act a riot of laughs.

The illustrious James S. Kolkowski and his Orchestra will entertain during this floor show and for dancing (10:30 p.m. to 1:30 a.m.).

You and Your Lady Are Invited!

Annual Reports

REPORT OF ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION, JUNE, 1955

This session was held June 6 to 10 in Atlantic City with a total over all registration of over 30,000, being one of the largest.

The House of Delegates' sessions were held June 6 to 9, inclusive, eighty resolutions were presented and studied.

Dr. Elmer Hess, President-elect, assumed the chair, with Dr. Dwight Murray, Chairman of The Council for several years, being unanimously named as his successor. Dr. Millard Hill of North Carolina was elected Vice President. Dr. James Reuling, Speaker of the House, was named as Dr. Murray's successor on the Board of Trustees, with Dr. Vincent Askey of California being chosen as speaker to succeed Dr. Reuling. Dr. Louis Orr of Florida was named Vice speaker.

The House of Delegates voted the 1955 Distinguished Service Award to Dr. Donald Balfour of Rochester, Minnesota. Dr. Balfour has been with the Mayo Clinic for nearly fifty years; at present, he is director of the Mayo Foundation for Medical Education and Research. Due to Dr. Balfour's illness, his son, Dr. William Balfour, accepted the award for his father.

The Clinical Session for this year will be held in Boston the first week in December. The 1956 Annual Meeting will be held in Chicago next June.

The scientific sessions were held daily, Monday through Friday, with emphasis on Cancer, Mental Health, Poliomyelitis, Geriatrics, Cardiovascular Disease and the newer drugs.

The specialty groups evidenced more interest than usual on the economic problems facing them in addition to their scientific discussions. This was especially so of the ophthalmologic section, in which the majority felt that the former ruling of the Judicial Council prevented them from maintaining as close a relationship with their patients as they deemed necessary. Therefore, they voted to widen the scope of the judicial ruling supported by the House of Delegates. From now on, this will permit them to follow to completion, in their own offices if they so choose, the examination, prescribing and fitting of glasses. Dr. Wilfrid Haughey of Battle Creek was very helpful in discussing this question forcefully and factually before the Reference Committee. Dr. R. H. Pino, of Detroit, also aided the Reference Committee in its deliberations on this topic.

In other phases, the Board of Trustees was authorized to appoint a committee for continuing study of economics in its relation to medicine. This follows out the Pino resolution to have the American Medical Association keep abreast of the changing economic picture. They have increased the personnel of the executive offices at this time.

The suggestion of the Ad Hoc Committee on Intern Study, not to deny recognition to teaching hospitals unless they failed to obtain 25 per cent of their quota for two successive years was passed. The former rule dropped hospitals if they failed to obtain 66.6 per cent for two successive years.

The subject of accreditation of hospitals came up for considerable discussion. Many felt that the hospital groups in certain areas were usurping the medical profession's perogative of being the predominant group to handle this question; therefore, a resolution was passed authorizing a special committee of the House of Delegates appointed to study and survey the work of the committee on accreditation and return suggestions at the next session. The committee members were not to be those who are on the Joint Committee on Hospitals or Hospital Accreditation committee at present.

A special committee to study medical practices, appointed some time ago, reported their findings in a seventy-page report recently to the Board of Trustees. This group, later on, gave certain portions of the report but withheld the report as a whole, due to the fact that it contained some critical material with direct quotations. The Board felt there might be some partial use of the material by those who wish to criticize and put different light on portions of the report.

Several members of the committee felt that the report in its entirety should be made available to all the members of the house; therefore, motion was made that action on the report be held over until the next meeting; in the meantime, all members of the House were to receive this report for study. Dr. Murray, Chairman of the Board, stated it was not the intention of the Board to withhold knowledge from the members of the House, but rather they felt it judicious not to publicize quoted material that might be construed adversely; further, all members were welcome to read the report. A subsequent report was the choice, so the motion was passed.

Director Draper of the United Mine Workers had designated his consulting group to pass on those who were to be admitted to this organization's hospitals, this method was disapproved by the House with a recommendation of free choice of physicians in these cases. This action was unanimously passed.

The question of voluntary social security had been discussed by county and state groups, especially by the younger men in many cases. The Michigan delegation, with its executive officers, felt that while the American Medical Association was against compulsory social security and successfully opposed it, they at no time disapproved the principle of allowing doctors of medicine to participate in Federal Social Security on a voluntary and self-employed basis; therefore, a bill was put in by us with the hope the American Medical Association would at least discuss this situation more freely in the journals for the benefit of those who are interested. The House disapproved of the American Medical Association's asking for a recommendation to the Congress of the United States to change the present status of Doctors of Medicine in relation to Social Security for fear that by once opening up the subject, it might weaken the American Medical Association's position on it and interfere with other legislation that might favor doctors, upon which they are now working. The House, however, did recommend the American Medical Association's thoroughly discussing this subject in THE JOURNAL in the near future. The fact that something of an enlightening nature will be forthcoming satisfied us to a certain extent.

The subject that provided the most discussion was the osteopathic question. Dr. John Cline reported, after nearly a three-year study, that his investigating committee, which visited five of the six osteopathic schools, found they were inferior to our medical schools and needed help both didactically and financially. It resolved into one of two things: either suppress them legally or elevate their standard by allowing Doctors of Medicine to teach in their schools. The resolution did not advocate recognizing osteopaths or osteopathy *per se*. After considerable discussion in committee, a majority and minority report reached the floor of the House. The minority report, which was adopted by the House of Delegates, stated:

"One member of the Reference Committee was completely satisfied that an appreciable portion of current education in colleges of osteopathy definitely does con-

stitute the teaching of 'cultist' healing, and is an index that the 'osteopathic concept' still persists in current osteopathic practice. Since he cannot, with good conscience, approve the recommendation that doctors of medicine teach in osteopathic colleges where 'cultism' is part of the curriculum, he respectfully makes the following recommendations to the House of Delegates:

"1. That the report of the Committee for the Study of Relations Between Osteopathy and Medicine be received and filed; and that the Committee be thanked for its diligent work, and be discontinued.

"2. That if and when the House of Delegates of the American Osteopathic Association, their official policy-making body, may voluntarily abandon the commonly so-called 'osteopathic concept,' with proper deletion of said 'osteopathic concept' from catalogs of their colleges; and may approach the Trustees of the American Medical Association with a request for further discussion of the relations of Osteopathy and Medicine, then the said Trustees shall appoint another special committee for such discussion."

The majority report of the reference committee, which was rejected by the House, made the following recommendations:

"Your Reference Committee, after a study of the report of the Committee for the Study of Relations Between Osteopathy and Medicine and the study of other evidence submitted, is not completely satisfied that the current education in colleges of osteopathy is free of the teaching of 'cultist' healing.

"In view of the desire to elevate the standards of teaching in colleges of osteopathy, your Reference Committee recommends approval of the recommendation of the committee that doctors of medicine may accept invitations to assist in osteopathic undergraduate and postgraduate medical educational programs in those states in which such participation is not contrary to the announced policy of the respective county and state medical associations. Such teaching services would be ethical.

"Your Reference Committee approves the recommendation of the committee that the House of Delegates request state medical associations to assume the responsibility of determining the relationship of doctors of medicine to doctors of osteopathy within their respective states or request their component county societies to do so.

"Your Reference Committee recommends that a committee be appointed at the discretion of the Board of Trustees to confer with representatives of the American Osteopathic Association concerning common or interprofessional problems on the national level."

The minority report was adopted by a vote of 101 to 81.

It is quite evident that we shall hear more about this question in the future.

Among a large number of actions on a wide variety of subjects, the House of Delegates also:

Commended the "Medic" television program;

Reaffirmed its previous recommendation that the United States withdraw from the International Labor Organization;

Approved the Headquarters Survey Report, which included the statement that "the only public relations program of any permanent value is the private and public relations of the individual doctor;"

Expressed regret that the Hoover Commission saw fit to alter or eliminate some of the recommendations of its Medical Task Force;

Reaffirmed its opposition to extension of the Doctor Draft Law;

Recommended the creation of an AMA Committee on Geriatrics;

Warned against the danger embodied in state legislative proposals designed to restrict the entire field of visual care to the profession of optometry.

Each year the work of the House goes more intimately into all phases of scientific and economic medicine which is a very healthy state for the American Medical Association.

Respectfully submitted,
Michigan Delegates to the
American Medical Association
W. D. BARRETT, M.D., Detroit
J. S. DETAR, M.D., Milan
W. H. HURON, M.D., Iron Mountain
R. A. JOHNSON, M.D., Detroit
R. L. NOVY, M.D., Detroit
W. A. HYLAND, M.D., Grand Rapids, Chairman

ADDENDUM

The Chairman wishes to express his personal appreciation to the delegates from Michigan, previously listed, and to the alternate delegates: W. W. Babcock, M.D., Detroit; O. J. Johnson, M.D., Bay City; C. I. Owen, M.D., Detroit; E. F. Sladek, M.D., Traverse City; J. R. Rodger, M.D., Bellaire; and G. W. Slagle, M.D., Battle Creek.

And to the officers: R. H. Baker, M.D., Pontiac, President; W. S. Jones, M.D., Menominee, President-Elect; William Bromme, M.D., Detroit, Chairman of the Council; L. Fernald Foster, M.D., Bay City, Secretary; Wilfrid Haughey, M.D., Battle Creek, Editor; Wm. J. Burns, LL.B., Lansing, Executive Director; J. Joseph Herbert, Manistique, Legal Counsel; and H. W. Brenneman, Lansing, Public Relations Counsel.

To these and many others of the Michigan State Medical Society, I wish to express my appreciation for their wise counsel and advice. Also the Delegates and Alternates, through me, wish to express appreciation to you, the members of the House of Delegates, for allowing us to represent your views in our parent organization, the American Medical Association.

Respectfully submitted,
WILLIAM A. HYLAND, M.D., *Chairman*
Michigan Delegates to the
American Medical Association

ANNUAL REPORT OF THE COUNCIL—1955

The Council has held three sessions totalling seven days, and the Executive Committee of The Council convened nine days (to September 25, 1955), a total of twelve meetings up to the 1955 Annual Session of the Michigan State Medical Society. This represented a total of 121 hours of deliberations—equivalent to 15 days and one hour on an eight-hour working basis—but as usual, not including additional time necessarily spent by the 25 members of The Council going to and returning from meetings which have been held in the various Councilor Districts.

All matters studied (978 items) and recommendations made by The Council's 21 Committees as well as by the Society's 20 Committees, and all business of the Society, were routinely referred to The Council or its Executive Committee for consideration and action.

Membership

Membership as of June 30, and as of December 31, from 1935 to 1955, is indicated in the following chart:

	1935	*1940*	*1945*	*1950*	*1953*	*1954*	*1955*
June 30	3,410	4,401	4,425	4,881	4,977	5,111	5,503
December 31	3,653	4,527	4,686	5,114	5,330	5,787	——

The figures for 1955 include 4,976 Active Members, 177 Emeritus and Life Members, 49 Retired Members, 294 Associate and Military Members, and 7 Honorary Members.

Finances

As in the past, the first item of new business on the monthly agenda of The Council or its Executive Committee is "Study of Monthly Financial Reports." Every

thirty days, therefore, the Society's financial picture is reviewed and governing policies established. In addition, the Finance Committee meets periodically to study and to advise The Council on particular fiscal questions.

The auditor's report for 1954 plus the budgets of the Society for 1955 were published in JMSMS, March Number, beginning on Page 356. Members are invited to acquaint themselves with the financial status of their State Medical Society and to offer suggestions; these always are truly appreciated. As of June 30, 1955, 4,976 members paid Society dues amounting to $124,-137.50. This was on the basis of $25.00 per member allocated to the General Fund as established by The Council in January, 1955, and includes some payments by new members of portions of a year. Also, $31,034.41 accrued to the Public Education Account, $17,379.11 accrued to the Public Service Account and $26,068.91 accrued to the Professional Relations Account for current activities as directed by The Council in January, 1955. The sum of $9,945.50 was set aside in a Building Fund as well as $7,459.13 in a contingent surplus fund. A brief financial résumé of each of the MSMS activities as of June 30, 1955 is, herewith presented:

Financial Report for Period Ending June 30, 1955

ACCOUNT	*On Hand 1/1/55*	*Income to 7/1/55*	*Expenses to 7/1/55*	*Balance on Hand 7/1/55*
General Fund	$ 73,452.24	$126,629.91	$ 86,939.72	$113,142.43
Annual Session	—0—	22,170.00	2,660.52	19,509.48
Mich. Clinical Institute	—0—	12,746.00	13,816.58	—1,070.58
The Journal	—0—	42,892.37	31,508.80	11,383.57
Public Education	76,816.26	31,161.17	18,261.82	89,715.61
Public Service	3,330.00	17,404.63	10,679.40	10,055.23
Professional Relations	6,545.92	26,106.91	15,500.63	17,152.20
Public Education Reserve	30,000.00	—0—	—0—	30,000.00
Rheumatic Fever Control	13,645.55	16,025.00	9,522.56	20,147.97
Surplus from Dues	29,390.82	7,459.13	—0—	36,849.95
Building Fund	11,770.04	9,945.50	2,799.09	18,916.45
Beaumont Memorial Fund	—10,480.29	200.00	—0—	—10,280.29
TOTALS	$234,470.54	$312,740.62	$191,689.14	$355,522.02

The AMA dues collected by county medical societies, forwarded to MSMS, and then mailed to the American Medical Association during the six months to June 30, 1955, totaled $121,837.50. The very high percentage of AMA dues being paid by MSMS members (97.9%) is to be noted; The Council feels that the members of our State Society are to be congratulated on their tangible co-operation with and support of the American Medical Association. A résumé of the financial condition of the Michigan State Medical Society as of August 31, 1955, will be presented to the House of Delegates at its opening session of September 26, 1955, as a part of The Council's Supplemental Report.

Thus far in 1955, $35,000.00 of the funds of the Michigan State Medical Society have been invested in short-term securities. These funds are invested during the early part of the year when income resulting from dues payments is high and thus earn interest for the MSMS rather than having the funds remain idle in a commercial account. These securities mature later in the year when income is low and expenses continue at the regular rate. Any securities maturing, the funds from which are not immediately required, will be reinvested upon the advice of the Finance Committee.

It should be noted that the Beaumont Memorial Fund is still in the red by $10,280.29. This amount was advanced by the Michigan State Medical Society to complete the building of this historical project. In addition, the Society paid expenses of the Beaumont Memorial Committee of $4,199.56 over the past three years.

The Journal

During the first half of its existence, the Michigan State Medical Society published a yearly book of transactions, but from 1902 it started THE JOURNAL as a monthly magazine which brought messages, information, news items, and scientific papers to the members every month, making for a much more closely knit medical profession.

The wisdom of Dr. Andrew P. Biddle, first Editor of THE JOURNAL, and The Council serving at that time, has been abundantly proven by the great progress in medicine, medical economics, social problems and community service from not only the leaders, but the profession in general.

It has been the privilege and duty of THE JOURNAL to pass on to our members, many new and valuable public relations and public service ideas. Today there is no more public spirited group than the medical profession of Michigan, carrying out the purposes of its establishment.

THE JOURNAL has always published the best of scientific material available, research, and committee reports, and has kept its readers well informed. It has also studied and presented the newest thought and the latest advances in all manner of improved services, adoption of new ideas, and in general we have presented very largely socio-economic editorials. We have tried to give our readers clear evaluations of books presented for review, as well as analysis of problems which face us, be they scientific or legislative.

We have succeeded in making THE JOURNAL of the Michigan State Medical Society different in several ways from the ordinary run of medical journals. For ten years at least, we have changed our cover with each issue, as well as putting special emphasis on the content, each JOURNAL being devoted largely to some specific activity of the Society. Since our last report, the August 1954 issue was devoted to our headquarters building in Lansing with special information about the building. Child Welfare and the Michigan Health Council were the subject of the September number, while October was devoted to diabetes with a special roster supplement. The November number carried a Christmas Seal on the cover and was devoted to tuberculosis. The December number was Michigan Clinical Institute, January—heart, and February was given over to maternal health with a special tribute to A. M. Campbell, M.D., who was much pleased when notified of this tribute before his death. March, April and May numbers were devoted to arthritis and rheumatism, cancer, and geriatrics, the last carrying an outstanding cover, "Grow Old Along With Me."

The June number was given over to Michigan Medical Service, and the cover was its Shield. July was devoted to the Annual Session, August to industrial health, and the rest of the numbers for this year have already been assigned.

We have had many comments about the roster supplement, all pleased, but some urging materially, that names be alphabetized, instead of listed by county, thereby making reference much easier in case one does not remember the county.

In preparing our editorials, we have continued to send "preview" copies to the Publication Committee and the administrative officers, and we are grateful to all of them who have sent us critical and helpful comments.

Organization

1. The Annual County Secretaries-Public Relations Conference was held in Detroit on January 30, 1955, with 157 attending.

The Council has converted this meeting for future years into a three-day seminar for all county society secretaries, presidents, presidents-elect, editors and public relations committee chairmen in order to make it a "down-to-earth" training school to effect better liaison and greater follow-through between the Michigan State Medical Society and its component societies—with the intent to develop better understanding and co-operation

between the state and county units. The initial Seminar will be held in Detroit, January 25-26-27, 1956.

2. The third annual meeting of Michigan's County Medical Society Executive Secretaries (seven) was held in Lansing February 9, with a program that stimulated greater organizational effort and understanding in mutual problems.

3. The Ninth Michigan Clinical Institute was held in Detroit March 9-10-11, 1955, with a record attendance of 2,980, including 1,786 M.D.s. Innovations included the accentuation of "What's New, Doctor, That You Can Use," a résumé of medical techniques and scientific advances developed in the last 365 days; also the use of closed-circuit color television, featured through the courtesy of Smith, Kline and French Laboratories, Philadelphia.

4. The usual semi-annual meetings of the six Delegates from Michigan to the American Medical Association, and also Grover C. Penberthy, M.D., Detroit, AMA Surgical Section Delegate, as well as the six Alternate Delegates, were held with the Executive Committee of The Council immediately prior to the June and December Sessions of the American Medical Association.

5. The Residents, Interns and Senior Medical Students Conference again was held in Detroit on March 9 coincident with the Michigan Clinical Institute with 138 attending. Since the future of medicine lies in the hands of these young men and women whose zeal—obvious at the March meeting—forecasts a good tomorrow for the medical profession and the people of this State, The Council plans a similar conference coincident with the 1956 Michigan Clinical Institute.

MSMS again sponsored financially the sending of delegates from Michigan's two medical schools to the Student AMA Convention in Chicago in May, 1955.

6. The 89th MSMS Annual Session in Detroit, September 29-30-October 1, was great in both quality and quantity—the latter being a record registration of 3,904, including 2,295 M.D.s.

7. National medical leaders from Michigan continue to increase in numbers: during the 1955 Michigan Clinical Institute, seven Michigan doctors of medicine were honored for achieving, during this year, the presidency of national medical associations: A. C. Curtis, M.D., Ann Arbor; L. A. Ferguson, M.D., Grand Rapids; W. A. Hudson, M.D., Detroit; A. C. Kerlikowske, M.D., Ann Arbor; H. M. Pollard, M.D., Ann Arbor; A. D. Ruedemann, M.D., Detroit, and C. C. Sturgis, M.D., Ann Arbor.

8. Indoctrination of new MSMS members. This project, recommended by the Secretary in his Annual Report to The Council, 1954, was referred to the individual Councilors to organize in their respective Districts, with the co-operation of their county medical societies.

The indoctrination of medical students was the study project of a special committee of the State Society. It developed that this work must necessarily be done outside the regular school curricula—on the free time of the students and at hours of their choice—and early in their medical school experience. The Committee recommended that this matter be referred to the Student American Medical Association as a project, with SAMA advising MSMS what the students would like in such a course, was adopted by The Council which also authorized a trial extension of the Residents-Interns Conference as a monthly orientation program for experimental purposes in the Metropolitan Area of Detroit. (See Annual Report of Committee on M.D. Placement Program).

9. The Past Presidents' Club was organized during the past year and held its initial meeting in Detroit on March 10. Twelve past executives were present to formulate plans and projects whereby the storehouse of experience and knowledge of this group can be utilized, for the benefit of the entire medical profession and the people of Michigan.

10. MSMS was host to the Midwest State Medical Officers Conference, in East Lansing, on November 20. Representatives of the state medical societies of Indiana, Illinois, Kentucky, Michigan, Ohio, and Wisconsin were present at this worthy thought-forum, which is to be an annual meeting, rotated among these midwestern states.

11. G. Thomas McKean, M.D., Detroit, was appointed on May 18 as Councilor of the Sixteenth District, to serve the unexpired term of W. D. Barrett, M.D., Detroit, resigned.

12. Organization among the fifty-five component county medical societies, covering all of Michigan's eighty-three counties, was maintained during the past year to a satisfactory degree. The scientific side of medicine in Michigan is at an all-time high. It is gratifying to note the many county and district society "Clinic Days" and the great increase in contributions to the medical literature by our members.

Public Relations

Undercurrents inimical to the private practice of medicine are becoming stronger. We have seen the Congress pass discriminatory legislation to draft our colleagues, as well as "liberalizations" of Social Security and other laws placing the federal government further into the practice of medicine.

With a friendly State Legislature, we have defeated, with difficulty, attempts to dictate our fee schedules as well as to open our profession and medical hospitals to irregular or substandard practitioners.

The words "Socialized Medicine" have become, in the public mind, a bogeyman which it need not fear, while at the same time the socialization of medicine continues.

Our professional services have been placed on the bargaining table in Michigan between labor and management with nationwide repercussions. In these negotiations we were not represented or consulted.

Meanwhile, through so-called governmental screening programs, which had their origins in others states, a successful invasion is being made of our position as diagnosticians and purveyors of the general physical examination service.

There are other, less obvious, public relations problems facing our profession. Possibly the most formidable of these is what appears to the layman to be a growing egoism or "better-than-thou" attitude on the part of a growing number of our profession.

During the past year we have carried on meetings with nearly every county medical society to assay each county society public relations program and to offer the ideas and services outlined in the MSMS brochure "Winning Friends for Medicine." We have found no Society that is not doing something along this line. Yet, we have found no Society that is doing its potential maximum. And we have found no Society that has reached out to its *every* member and impressed him with the necessity for interest and work in this field of Society endeavor.

We continue to receive national recognition of our PR program, the latest being the ATAE (American Trade Association Executives) Award for Outstanding Service by a state association made in appreciation of our Medical Associates program.

For the tenth consecutive session of the Michigan Legislature, no legislation was passed that is inimical to the health interests of the people of the State of Michigan.

The use of communication media (as outlined in the report of the Public Relations Committee) has continued at an acceptable pace.

The advice of the MSMS has been sought and given on innumerable questions of health by the people directly as individuals and by organizations which represent their varied health interests.

Among all organizations representing the various professions, medical societies continue to lead the way in

public relations activity, with MSMS taking its share of this leadership. This has been aided by the loyal service of the MSMS executive staff.

While the medical profession is proud of its accomplishments in the field of public relations, there is every indication that we must continue our activities, if the private practice of medicine is to be preserved. Unless we are to reconcile ourselves to the socialization of our profession, every MSMS member must continue to take an individual interest and wholeheartedly participate in an intensive, well-planned PR program.

Woman's Auxiliary

Under the presidency of Mrs. (Albert F.) Beth Milford, the Woman's Auxiliary to the Michigan State Medical Society has enjoyed a very successful year. For the first time, Michigan received a national award for being 100 per cent in the American Medical Education Foundation. Michigan also received a national award this year and a check for outstanding achievement in Today's Health subscriptions. We spent $8,841.00 in nurse recruitment which was almost double what we did last year. Twenty-seven of our counties gave either a loan or a scholarship to nurses.

Over 5,000 pieces of literature from the American Medical Association office in Chicago were distributed to over 100 PTA groups. The *Today's Health* reprint "Is He Ready for Kindergarten" was used in preschool clinics throughout the State and in the Sparton Nursery School in Civil Defense. Seventy-seven schools in thirty-five counties participated in our tuberculosis speaking contest.

The Michigan State Medical Society is proud of its Auxiliary.

Contacts with Governmental Agencies

Contacts with federal, state and local governmental agencies continue to be an important activity of the Michigan State Medical Society. The more important contacts during the past year included:

1. Michigan Day in Washington, D. C. Again, MSMS representatives visited Washington, D. C., on May 2-3, 1955, pursuant to instructions of the 1954 MSMS House of Delegates, to make personal contacts with our friends in the Capitol, with resulting increase in good will.

A recommendation on this subject follows.

2. The usual number of contacts were maintained during the past year with the Michigan State Board of Registration in Medicine, University of Michigan, Wayne University, State Board of Alcoholism (which invited MSMS to help plan its 1955 Conference on Alcoholism in Kalamazoo), Michigan Crippled Children Commission, Michigan Department of Public Instruction, Michigan Social Welfare Commission, Michigan Insurance Department, Michigan Advisory Hospital Council, State Sanatorium Commission, Veterans Trust Fund, Michigan Civil Defense, Michigan Mental Health Commission, members of the Michigan Legislature (see paragraph on Public Relations and Legislation), and the United States Congress.

A proposed Liaison Committee with the State Executive Office was nominated and transmitted to Governor G. Mennen Williams for his consideration and decision.

3. Liaison with the Michigan Commissioner of Health continued to be frequent and co-operative. Throughout the year, matters of mutual interest were discussed by and with Dr. A. E. Heustis at meetings of The Council and its Executive Committee including the multiphasic screening program, a six-county survey completed in June, 1955.

Contacts with Voluntary Agencies and Organizations

1. Blue Shield, Michigan Medical Service has continued to enjoy amazing success in its 15th year of existence. Financial reports of Michigan Medical Service will be submitted to its Members at their annual meeting on Tuesday, September 27, 1955, at 2:00 p.m. in the Grand Ballroom of the Pantlind Hotel, Grand Rapids. R. L. Novy, M.D., MMS President, urges all MSMS Delegates (who *ispo facto* are Members of Michigan Medical Service) to be present at this session to insure a quorum necessary for the conduct of business.

2. More and more voluntary organizations request representation on their boards and committees or at their meetings and conferences from the Michigan State Medical Society. The Council expresses its sincere thanks to all MSMS members who sacrificed time and effort to act as official MSMS representatives for the following organizations: Michigan Hospital Association; National Citizens Committee for Educational Television; National Hospital Record Librarians; Michigan League for Nursing; Operating Room Nurses Association; Conference on Physicians and Schools; Michigan Rural Health Conference; Michigan State Pharmaceutical Association; Michigan Health Council; National Rural Health Conference; Michigan Association of Health Officers; Adult Education Association of Michigan; American Medical Education Foundation; County Medical Society Civil Defense Conference; Michigan Association of Ice Cream Manufacturers; American Medical Writers Association; American Public Health Association; Conference on Mental Health; Detroit Area Hospital Council; Student AMA; Detroit District Dental Society; State Bar of Michigan; Council on Medical Education and Hospitals of AMA; Conference on Aging; Council on Federal Medical Service; World Medical Association; Michigan State Dental Society; Children's Services Forum; Congress of Industrial Health; American Academy of Pediatrics Committee on Welfare of Fetus and Newborn; the Ontario, Kentucky, Illinois, Ohio, Wisconsin and Georgia State Medical Societies' Annual Sessions; National Conference on Physicians and Schools; Joint Conference on Maternal Mortality Committees; Michigan Hospital Service; Royal Sanitary Institute of London, England; Research Council for Economic Security; and the Midwest Conference on Arthritis.

Salk Polio Vaccine

In The Council's Supplemental Report, submitted to the 1954 MSMS House of Delegates, the following paragraph summed up our viewpoint on Salk polio vaccines of September 27, 1954:

"None knows, or will know until 1955, that there has been protection against epidemic poliomyelitis by virtue of the inoculations or that there has been significant increase in antibody titer in the blood of those inoculated—whether this increase is to the level of producing immunity or not. No one has indicated to anyone whether this patient of yours received the vaccine or the control, and it is impossible to state that the proprietary vaccine of the National Foundation (for Infantile Paralysis), in reaching the mass market first, has made a significant contribution to the mass control of epidemics."

The muddled and controversial situation involving Salk polio vaccine at the present moment suggests that The Council's report to last year's House of Delegates was prophetic. Even today, "no one knows." As recent as June 15, not even Michigan's Health Commissioner had knowledge of the Salk polio vaccine situation other than that which had been appearing in the newspapers!

Despite this lack of knowledge and the confusion surrounding the mass inoculation program, the Michigan State Medical Society co-operated to the fullest and formulated some recommendations as a public relations gesture in this public health emergency. On April 20, 1955, the Executive Committee of The Council made the following UNPRECEDENTED recommendation to all component county medical societies of Michigan:

"That the injections of the vaccine by physicians in their offices be done for a special fee of $2.00 per injection—this to be in addition to the actual cost of the

vaccine—this special fee to hold only during the emergency period while the vaccine is in short supply and the hypersusceptible groups are not protected."

The Michigan State Medical Society continues to offer co-operation and nominated Vice-Speaker K. H. Johnson, M.D., Lansing, as its representative to the State Advisory Committee on Polio Vaccine Distribution, which, with the Health Commissioner's Advisory Committee on Immunization, is endeavoring to organize an orderly program for the benefit of the youth of this state. The medical profession's position was best stated by the Executive Committee on April 20:

"The medical profession is making its contribution in the present public health emergency to the end that all eligible persons may have the vaccine in the office of the physician of their choice."

Beaumont Memorial Restoration

The Beaumont Memorial at Mackinac Island was dedicated July 17, 1954—a monument that will stand for generations as a symbol of the honor and respect which Michigan medical men pay to their scientific Great. During the past year, a magnificent gift was presented by MSMS President-Elect and Mrs. W. S. Jones to the Memorial: eighty extremely valuable books of the Beaumont era, repaired for long preservation through the courtesy of the University of Michigan; in addition, Dr. and Mrs. Jones presented to the Beaumont shrine a special handmade wrought-iron grill to protect these priceless volumes on display in the Memorial.

Another gift to the Beaumont Memorial was received from the St. Louis Medical Society; the bed used by Dr. Beaumont during his lifetime. High thanks are due and payable to Dr. and Mrs. Jones and to the St. Louis Medical Society; also to the Wayne County Medical Society for the repeated loan of its valuable painting, "Dr. William Beaumont," on display for the past two summers in the Memorial.

Additional monies are needed to reimburse the Michigan State Medical Society to the extent of $10,280.29, the sum which the Society loaned to complete the Memorial. Less than 50 per cent of MSMS members have contributed to the building of the Memorial, an architectural and historical gem that belongs to *all* members of the medical profession and should be the financial responsibility of each and every practitioner of medicine in this state.

A recommendation on this subject follows.

Committees

A total of sixty meetings of committees of the Michigan State Medical Society and of The Council were held during the past year (up to September 1, 1955).

Progress of the Michigan State Medical Society continues to be due, in the main, to these active groups. The Council commends to your careful perusal and consideration the Annual Reports of all Committees. The Council expresses gratitude to the chairmen and members for their tangible contributions of time and effort given on behalf of *all* members of the Michigan State Medical Society and for the benefit of the public of Michigan.

The new Study Committee on Mediation, Ethics, and Grievance reported a summary of objectives to the Executive Committee of The Council in June; these objectives will be framed for presentation as changes in the MSMS By-Laws, if possible, before the 1955 Annual Session of the House of Delegates.

Especially active during the past year were the following Commitees: Child Welfare Committee; Geriatrics Committee; Legislative Committee; Maternal Health Committee; Mental Health Committee; National Defense Committee; Rheumatic Fever Control Committee; and the Rural Medical Service Committee.

Annual Reports of Committees of the Council

To save the time of House of Delegates' Reference Committees, the Annual Reports of Committees of The Council are being integrated into the Annual Report of The Council, as follows:

Committee to Co-operate with the Michigan Health Council re Periodic Health Appraisal.—This committee has had but one meeting since the last report, but a great deal of work has been done during the year. With the active support of The Council, a Minimal Periodic Health Appraisal Card has been developed and sent to all members of the Michigan State Medical Society. Articles on the subject of Periodic Health Appraisal, prepared by various members of the Committee, have regularly appeared in JMSMS; the Committee on Postgraduate Medical Education has actively co-operated by placing speakers on this subject on "The Michigan Program for Graduates in Medicine"; a motion picture will be developed on this subject; speakers on the subject have been on the programs of the Michigan Clinical Institute, are planned for the Michigan State Medical Assistants Society, and even the Student AMA Convention; MSMS Councilors are actively promoting Periodic Health Appraisal throughout their representative areas; and an exhibit was prepared for the Annual Session of MSMS.

The committee has felt that its work should be directed toward the medical profession in fostering and developing adequate Periodic Health Appraisals, but that the subject should not, as yet, be one of public information since there is already a great deal of material appearing in various media which urges all individuals to undergo regular health appraisal examinations.

The committee feels that this is an important project; that it has a great deal of work still in progress; and that this committee should be continued.

Committee on Health and Accident Insurance Policy Control.—No meetings of the committee have been held since September, 1954. At the present time there are two cases pending, one of a very recent origin, the other of long standing. It was thought the latter case could be closed by mutual arrangement between the doctor involved and the insurance company, both agreeing to the procedure. However, the doctor could not make his information available to the insurance company before the week of June 13 and since that time no statement has been forthcoming. The first case involves a technicality in which two errors apparently have been made, one by the physician involved, the second by the insurance company. Clarification of the issue by the insurance company is now pending and a letter expected momentarily.

Special Committee to Meet with Michigan Social Welfare Commission.—As in the past four years, this committee has formed the major part of a larger advisory committee under the Chairmanship of Milton Shaw, M.D., of Lansing. We have met at the call of the Director of the Welfare Department a total of six (6) times since September, 1954. Various problems were studied and recommendations made, including reappraisal of the Totally Disabled and Aid to Dependent Children categories; the adoption of "actual cost" medical care in certain counties; review of medical and surgical care at Boys Vocational School; and many other important matters.

The Social Welfare Commission has again thanked this committee for its valuable contributions and respectfully requests a continuation of same in the future.

Medical Procurement Advisory Committee.—This committee held no meetings during the past year since no problems arose which called for a meeting and no references were made by officers or committees of the Society which required consideration.

However, various members of the committee have served in various capacities in medical procurement. Dr. Grover C. Penberthy continues as chairman of the Voluntary Advisory Committee to the Selective Service System and your chairman as Medical Advisor to the Director of Selective Service for Michigan.

Committee on Atomic and Allied Procedures.—This committee held no meetings during the year. The chairman had several personal discussions with members of the committee, also a few telephone discussions. There were no projects warranting a calling of the full committee.

Committee on Rural Medical Service.—This committee met several times during the year and considered a number of subjects. The principal one was the M.D. Placement Program, co-operating with the Michigan Health Council in this respect. Much progress has been made in this program and several specific situations were discussed and decisions made. It is felt that the M.D. Placement Program has done a lot to alleviate the doctor shortage in critical areas and also to promote public relations between the MSMS and the citizens of Michigan as a whole. This indicates the desire of doctors to help in relieving the shortage of trained medical personnel throughout the State.

Several of the committee members attended the National Conference on Rural Health in Milwaukee in Februrary, 1955, and felt that it was a very profitable trip and meeting. Other items of note discussed during the year included the planning of a panel for the program featuring Drs. Furstenberg and Scott at the Delegates luncheon in September, 1955. The Committee was vitally interested in possibilities inherent in the preceptorship plan for the State of Michigan, also in the planning of a possible Senior Day or other form of activity for the medical students of Wayne and University of Michigan Medical Schools, and the co-operation between the Committee members and the various Council members in regard to public relations between local communities and the Michigan State Medical Society.

National Defense Committee.—This committee met three times during the past year. The attendance was excellent and problems of national and local defense were covered.

Many members of the committee and activators, the heads of National Defense of Michigan and of the City of Detroit, as well as representatives of State Headquarters, Dental, Nursing and Hospital Administration were present.

Discussions were based on medical care—some of the following were considered:

1. Following a major accident.
2. Following an atomic blast.

Evacuation (in the proposed evacuation system which is under consideration).

3. Types of casualties to be expected and the priorities of the different types of casualties.
4. Preparedness for the care of casualties of an atomic disaster were discussed, in detail:

(a) "First Aid" training for each and every citizen, starting in the grammar schools. This course should be more intensive than those presented at this time. Certain required training should be eliminated and more pertinent training added. "Buddy Aid" should be taught.

(b) Blood typing, procurement, storage and blood substitutes and expanders were discussed fully. (These are important in emergency and definitive care of the different types of wounds from an atomic blast.) Dextran, an expander, was considered to be one of the important and valuable drugs for the treatment of shock, burns and fractures.

(c) Radioactivity: its detection and care, and the treatment of complications.

(d) Triage.

(e) Sanitation, food, water supply, public health, et cetera—if blast occurs.

(f) Re-check, at this time, vaccinations against small pox, typhoid, tetanus, diphtheria, scarlet fever, and all communicable diseases.

(g) Emergency hospitals.

(h) Use of all medical and para-medical personnel including nurses, dentists, veterinarians, laboratory technicians, dietitians, and former armed forces medical personnel.

Many of our members have attended national defense meetings in Chicago, Washington and other cities and have returned with material which will profit our state and local organizations.

Committee on Arbitration.—The committee attempts to advise fair, equitable and uniform fees for certain medical services rendered to governmental agencies. In the first six months of the 1954-55 year, the committee held two meetings and reviewed sixteen (16) cases. Judging from past experience, we presume we will have about two more formal meetings and review about forty (40) cases during the year.

Committee on Courses on Medical Economics and Ethics.—In all, nine lectures were given to the senior medical students at the University of Michigan.

On October 1, the chairman presented a talk on "Medical Public Relations" which included a discussion of the personal factors which relate to the physician himself and also to the public relations value of a good office examination and treatment.

On November 10, Warren R. Mullen, M.D., of Pentwater, gave a lecture on "Starting Practice."

On December 8, Professor Charles Joiner, of the University of Michigan Law School, put on a court demonstration in which a witness was interrogated and caught up on several errors. At the end of the demonstration Professor Joiner pointed up these errors in a ten-minute talk.

On December 15, John S. DeTar, M.D., Milan, gave a talk on "General Practice."

On February 2, Lawrence A. Drolett, M.D., Lansing, chairman of the Legislative Committee of the Michigan State Medical Society, spoke on "The Relation of the Physician to the Legislature."

On February 9, Kenneth H. Johnson, M.D., Lansing, Vice Speaker of the MSMS House of Delegates, spoke on "Selection of a Career in Medicine." In this talk many of the personal phases of the selection and working out of a career in medicine which are fundamental to the actions and the relations to the patient were pointed out.

On February 23, Ralph A. Johnson, M.D., Detroit, one of the Delegates of the MSMS to the AMA, spoke on "The Relation of the Physician to Organized Medicine."

On March 9, a panel consisting of the entire Ethics Committee of the Washtenaw County Medical Society held an open meeting before the students, at which time six applicants for membership in the Society were present. This meeting took the place of the required session with the Ethics Committee prior to any applicant's being passed upon.

On March 16, two films, "The Picture of Health" and "A Citizen Participates," were shown in order to acquaint the students with the material on film which is available.

A similar program is being carried out at Wayne University under the direction of Dr. R. I. McClaughry, Assistant Dean, and while your committee has had no direction in this work, it has been furnished with complete information by Dr. McClaughry. It is our opinion that the program being carried on at Wayne is of excellent content.

Committee to Meet with the University of Michigan.—This committee met in September 1954. As a result of the meeting, the committee was promised a "letter of policy" by the University Hospital from Roger B. Nelson, M.D. The next meeting of the committee is contingent on the receipt of this letter.

Hospital Relations Committee. — The Michigan Supreme Court ruling in the Gogebic County (Grand View) Hospital case and subsequent litigation entered in Allegan County Circuit Court by a doctor applying the Supreme Court findings to a community hospital, supplied

the foundation for this committee's major work during 1954-55. The Supreme Court declared that the Board of Trustees of Grand View hospital had usurped authority not granted in Act No. 350 of the Public Acts of 1913 under which this and seven other county-owned Michigan hospitals operate. In denying that the Grand View trustees had power to regulate the professional staff of the hospital according to the language of Act 350, the Supreme Court established a precedent considered dangerous from the medical viewpoint since medical and surgical care would be provided without adequate supervision. On January 26, this Committee met jointly with the Hospital Relations Committee of the Michigan Hospital Association, officers of MSMS, and Legal Counsel of MSMS, to determine a course of action with which to meet these hospital problems. Agreement was reached on several points, and action was taken immediately on several of these. With subsequent approval of The Council, the following conclusions and recommendations were made: (1) a re-examination of the bases upon which rules are being formulated in various types of hospitals throughout Michigan was indicated to see that all such rules are predicated upon reason and fairness; (2) that the Allegan Health Center litigation was of unusual urgency and import to the people, the Michigan Hospital Association, and MSMS, and that each of these organizations should engage separate legal counsel to bring this suit to a successful termination; (3) that active support be given the individuals and local organizations named as defendants in the Allegan suit; (4) that MHA, with MSMS co-operation, should vigorously pursue the amendment of Act No. 350 of Public Acts of 1913 during the 1955 Michigan Legislature in order to rectify the situation caused by the Grand View Hospital Case; (5) that an effort might well be made to establish standards for hospital constitutions and by-laws which could be recommended to hospitals in Michigan, and (6) that much could be gained by periodic meetings between committees of MHA and MSMS to work out areas of agreement and plans for the solution of common problems.

Subsequently, a vigorous defense was initiated in the Allegan Health Center litigation, with close co-operation from counsel for the other organizations and individuals named as defendants. The court's first ruling in the case, which denied the plaintiff a temporary injunction, was favorable to MSMS and its co-defendants. The final outcome is still forthcoming. Meanwhile MHA also sponsored legislative amendments to Act No. 350 of the Public Acts of 1913 designed to correct the flaws uncovered by the Supreme Court, and MSMS gave strong support in the effort to have this bill passed in the 1955 Legislature. The amendments were embodied in House Bill 362 (see report of Legislative Committee for details).

Committee on M.D. Placement Program.—This committee has had two meetings and considerable correspondence in regard to indoctrination talks to medical students.

At the present time, there is some word concerning the practice of medicine being given to the medical students in their senior year, but outside of the regular curriculum the committee feels that the work of indoctrination should be given in the freshman year and continue through the senior year.

The committee recommends that this matter be referred to the Student American Medical Association as a project with the SAMA advising the MSMS what the students would like to have in such a program; and that the SAMA recommendation also be forwarded to the AMA.

Medical Advisory Committee to the Michigan United Fund.—The first meeting was held on October 28, 1954, and was devoted to organizational problems. The following motion was adopted:

That the functions of this committe be:

1. Evaluation of new programs viewed in the light of type of service, prevention of duplication of service, organization of the program, and adequate area coverage in the State;

2. Medical analysis of established programs viewed in the light of effectiveness of service and desirability of enlargement or limitation of activities;

3. A relative evaluation of programs in comparison with one another from these same angles of population and area covered as well as medical need within a community.

On March 30, 1955, the committee held its second meeting. A fourth function of the Advisory Committee was added to the original three, as follows:

4. Evaluation of medical research for cure and prevention of disease as well as rehabilitation programs.

Also at this meeting, the request of the Michigan Multiple Sclerosis Society, through its representatives, was considered, and the committee recommended approval of their program subject to the approval by the Wayne County Medical Society. This action subsequently was adopted by the MSMS Executive Committee of The Council.

Matters Referred to The Council by the 1954 House of Delegates

1. *Periodic Health Examinations by Hospital Staffs.*—Following specific recommendation by last year's House of Delegates, The Council appointed a Study Committee composed of: O. B. McGillicuddy, M.D., Chairman, L. J. Bailey, M.D., V. N. Slee, M.D., and E. P. Vary, M.D. The report of this Study Committee is as follows:

The Committee on the Study of Periodic Health Examinations in Hospitals met on June 1, 1955. A questionnaire to Michigan hospitals revealed that only nine give such examinations to executives.

"The Committee felt that the Michigan State Medical Society should be concerned with the ethical presentation of the participating doctor's bills to the patients; the criteria used by the hospital in choosing staff doctors for these examinations and the great expansion of hospital population that may result from these examinations."

2. *Traffic Safety*—A special committee of The Council was appointed to carry through the instruction of last year's House of Delegates, the personnel being J. R. Rodger, M.D., Chairman, W. W. Babcock, M.D., A. Z. Howard, M.D., H. T. Johnson, M.D., H. J. Meier, M.D., and C. L. Straith, M.D. This Committee submitted the following annual report:

"There are so many facets to the complex problem of traffic safety and so many groups working on it that your Committee feels it has spent the year wisely in exploring the specific areas in which the medical profession could be of the greatest help. Three meetings of the Committee were held during the year, some of them being with representation from the offices of the Michigan State Police, the State Safety Commission, and the State Toxicologist.

"The mid-winter meeting was spent primarily in legislation connected with traffic safety, and study was given to bills on voluntary chemical tests for alcoholism, driver training, maximum speed laws and increased numbers of state police. With the exception of the latter, all these bills died in committees of the Legislature.

"At its spring meeting the Committee learned that in Michigan in 1954 the highway fatalities decreased 6 per cent in spite of increased registration and mileage driven, and that the highway mortality *rate* on the basis of miles driven had decreased 9 per cent. The Committee discussed but took no action on problems of car design, since there is now AMA representation on such a Committee of the National Safety Council.

"The Committee recommends to the House of Delegates that the Committee be continued during the coming year with the main activity being to follow educational lines rather than legislative activity, and that it approach the highway accident problem through driver training, Parent Teacher Associations and other similar groups,

stressing medical aspects of preventing highway accidents, including co-operation with other interested groups studying this same problem. It was also the recommendation of the Committee that its membership next year should be enlarged to include representation from the specialty fields of eye, ear, nose and throat, internal medicine and psychiatry, and any other pertinent specialty that might add to the knowledge of the cause and prevention of highway accidents."

3. *Migrant Workers.*—The possibilities of health screening procedures of all migrant workers, by their employers in co-operation with Blue Shield, were referred (in Secretary's Letter No. 175) to the component county societies for action. Results can be assayed only at the end of the 1955 harvest season.

4. Panel on Undergraduate Medical Education with the Medical School Deans. This is the feature of the House of Delegates luncheon scheduled for Monday, September 26, 1955, Pantlind Hotel, Grand Rapids.

5. Increase by Michigan Medical Service of fees for anesthetists. As instructed, this matter was referred to the Medical Advisory Committee to Michigan Medical Service ("without recommendation" of the 1954 MSMS House of Delegates). The Committee's report reads: "Anesthesia fees and problems of rendition of anesthesia are still being studied by the Staff and Medical Advisory Committee of Michigan Medical Service."

6. Greater Uniformity by Basic Science Boards. This Resolution was referred to the Committee on Study of Basic Science Act, composed of H. A. Furlong, M.D., Chairman, D. W. Thorup, M.D., C. E. Umphrey, M.D., and Mr. J. Joseph Herbert, Advisor. The annual report of this Committee is as follows:

"The activities of the Committee on Study of Basic Science Act have been directed towards additional improvements in this legislation. This has been accomplished by a series of telephone conferences with the MSMS Legislative Committee, the Michigan State Medical Society headquarters staff, the MSMS Legal Counsel, and the Committee members. The Committee participated in a hearing before the Public Health Committee of the House of Representatives.

"Amendments to the Basic Science Law (HB 415) as finally enacted by the 1955 Legislature further increase the discretionary powers of the Basic Science Board as follows:

(1) Certificates in Basic Science may be granted to applicants by the Michigan Basic Science Board in lieu of examinations provided the applicant presents a certificate from any legally constituted examining board in the healing arts, from any state or territory and providing the examination was equivalent to the Michigan Examination.

(2) The Amendment places the burden of presenting proof upon the applicant rather than requiring the Basic Science Board to obtain proof of the examination taken by the applicant. This has been a successful provision of Basic Science laws in other states."

7. *Information by Blue Cross-Blue Shield to Contract Holders.*—Intelligent follow-through on this Resolution has been done by Michigan Hospital Service and Michigan Medical Service. First, an excellent "Question-and-Answer" brochure was printed and distributed to all members of the Michigan State Medical Society explaining contract provisions and their interpretation; in addition, office plaques entitled "To All My Patients," based on an AMA plaque, were supplied to all M.D.'s to encourage free discussion by patients of medical services and fees. Secondly, all new subscribers of Blue Cross-Blue Shield are receiving literature (revised since September, 1954) explaining the benefits and especially the exclusions of the contracts. Moreover, the advertising program and all literature to enrolled groups attempts to clarify the contract provisions.

8. *Expansion of AMA Administrative Facilities.*—Your Michigan Delegates to the AMA House of Delegates followed the instruction of the 1954 MSMS House of Delegates and presented a Resolution in Miami last December asking that the AMA Board of Trustees appoint a committee to study the matters set forth in this Resolution. A Study Committee was appointed by the AMA Board of Trustees which reported to the House in Atlantic City, June, 1955, indicating progress in the streamlining of AMA's administrative setup. For complete report see *JAMA* of July 2, Page 747; also Annual Report of Michigan's Delegates to AMA, published in 1955 Handbook for Delegates.

9. *Study of General Practice by AMA.*—Your Michigan Delegates to the AMA House of Delegates followed the instruction of the 1954 MSMS House of Delegates and presented a Resolution at the Miami meeting—December, 1954, calling upon the AMA to initiate an exhaustive study of the whole problem of the general practice of Medicine. A Study Committee was appointed by the AMA Board of Trustees which has been laboring on this overwhelmingly complex subject. A résumé of the Committee's progress report was submitted to the AMA House in June; copies of the complete report are to be sent to all members of the House so that final action may be considered in Boston, December, 1955. See *JAMA* of July 2, Page 750 et seq; also Annual Report of Michigan's Delegates to AMA, published in 1955 Handbook for Delegates.

Legal Actions

In the past year, the Michigan Supreme Court held for the plaintiff (Samuel G. Albert, M.D.), in the case against the Grand View Hospital Trustees at Ironwood. As a result, in the eight hospitals operating under this special County Hospital Act, the Board of Trustees is not permitted to regulate the admission or conduct of its medical staff. (Relief from this unhealthy situation was sought from the Legislature in H.B. 362, previously described.)

This case undoubtedly stimulated the suit of Wm. A. Kopprasch, M.D., vs. Allegan County (hospital) Health Center, its Trustees, its Medical Staff, the Allegan County Medical Society, Michigan Hospital Association and the Michigan State Medical Society. Dr. Kopprasch demanded the use of the community hospital for his practice and seeks injunctions and damages in excess of $250,000. The potential danger to hospitals and their staffs arising from this case resulted in The Council taking prompt action to defend itself as well as the Allegan County Medical Society "to whatever extent is necessary." The legal counsel of all defendants have co-operated well in this case, still a matter of litigation. However, the first round, decided on May 10, 1955, was lost by the plaintiff when the court refused him a temporary injunction by reason of the fact that he never had made proper application to become a staff member of the Allegan Health Center.

The members of the Allegan County Medical Society are especially to be congratulated on their vigorous defense of their rights in this legal controversy which affects all medical men who practice in the hospitals of Michigan and the United States.

Respectfully submitted,

WILLIAM BROMME, M.D.
Chairman of The Council
H. B. ZEMMER, M.D.
Vice Chairman of The Council
ARCH WALLS, M.D.
R. S. BREAKEY, M.D.
G. W. SLAGLE, M.D.
RALPH W. SHOOK, M.D.
J. D. MILLER, M.D.
H. H. HISCOCK, M.D.
L. C. HARVIE, M.D.
G. B. SALTONSTALL, M.D.
F. H. DRUMMOND, M.D.
W. M. LEFEVRE, M.D.
B. T. MONTGOMERY, M.D.

T. P. WICKLIFFE, M.D.
B. M. HARRIS, M.D.
D. BRUCE WILEY, M.D.
G. T. McKEAN, M.D.
W. B. HARM, M.D.
J. E. LIVESAY, M.D., *Speaker*
K. H. JOHNSON, M.D., *Vice Speaker*
R. H. BAKER, M.D., *President*
W. S. JONES, M.D., *President-Elect*
L. FERNALD FOSTER, M.D., *Secretary*
W. A. HYLAND, M.D., *Treasurer*
L. W. HULL, M.D., *Immediate Past President*

Recommendations

1. That The Council be authorized to send MSMS representatives to Washington, D. C., in 1956, on the occasion of the Annual Michigan Day.
2. That contributions to the Beaumont Memorial Restoration Fund—by every individual MSMS member—be urgently recommended by the 1955 House of Delegates. Every member of the Michigan State Medical Society should take pride in contributing to the Beaumont Memorial which will represent for generations the best type of public relations for the medical profession of this state.
3. That each individual member of the MSMS House of Delegates pledge himself to further in his community or area the MSMS periodic health appraisal program to the end that private medical practice will bring—in full measure to all people of this state—the life lengthening health protections afforded by modern medical science. The doctor of medicine must keep in mind that this program is one desired by the people; and people usually secure what they demand—if not by voluntary means, then through compulsory legislation.
4. That, in these times of change, The Council trusts that it will continue to merit your continued support, co-operation, and faith.

ANNUAL REPORT OF LEGISLATIVE COMMITTEE—1954-1955

Although the medical profession fared very well in the 1955 Michigan Legislature, it was perhaps the most difficult session in recent years. It was complicated by the emotional impact of the release of new poliomyelitis vaccine, by an all-out legislative drive by chiropractors, and by a well-directed effort to confuse legislators on a vital piece of hospital legislation with misinformation and irrelevant side issues. Of interest was a change in the Basic Science Law, which was amended for the third time in as many years.

All in all, MSMS was required to marshal great strength in meeting the challenges of the 1955 Session, and MSMS representatives were required to exert even more time and energy than in the hectic sessions of 1953 and 1954.

A total of 952 measures were introduced and given consideration by one or both houses of the Legislature, and—following the usual pattern—approximately 10 per cent of these were of interest to the medical profession in large or small degree.

A total of 95 bills demanded the attention of MSMS, with a large number of them requiring direct action on the part of the medical profession and its spokesmen.

Grave threats to the health and medical welfare of the people of Michigan were posed by a series of dangerous measures which *failed to pass* but which might well have become law had members of the Legislature not been able to get authoritative information and counsel from MSMS, aided by the co-operation of related organizations dedicated to retaining high medical and health standards in Michigan. Except for positive action to halt these measures, the people of Michigan might well have been saddled with:

—One of two proposed new definitions of chiropractic authorizing chiropractors to engage in various phases of medicine far beyond their qualifications, using instruments and practices dangerous in the hands of the unskilled or untrained. (H.B. 289, killed by the Senate Committee on Health and Welfare; S.B. 1313, killed in Senate Committee on State Affairs.)

—A new "healing art" to be carried on by "naturopathic physicians" with their meager training, giving them their own examining and licensing board, the right to use the title "doctor" and authorizing them to use a method of treatment based solely on cultist philosophy. (H.B. 348, died in the House Committee on State Affairs.)

—An amendment to the Basic Science Art, which would have thrown a time-consuming and complicated burden on the Basic Science Board. (H.B. 415, carefully revised to workable form by House Committee on Public Health, with important amendment added by the Senate Committee on Health and Welfare.)

—Transfer of one of the state's largest tuberculosis hospitals to use for domiciliary care of mentally defective children without adequate survey of Michigan's tuberculosis needs, and use of a smaller, obsolescent institution for a similar purpose. (S.B. 1387, died in Senate Appropriations Committee; S.B. 1215, died in Senate State Affairs Committee; H.B. 350, killed by the Senate Appropriations Committee.)

—Abolition of the Tuberculosis Sanatorium Commission, Office of Hospital Survey and Construction, and Advisory Hospital Council as independent agencies, centralizing power in the State Health Department. (H.B. 424, killed in the House State Affairs Committee; S.B. 1317, killed by the Senate State Affairs Committee.)

—A program for training practical nurses in unregulated public school facilities, rather than in well-staffed and well-administered training centers. (S.B. 1252, killed by Senate State Affairs Committee.)

—A precedent of stipulating by law the fee for professional services of a physician for vaccinating private patients, and the appropriation of tax money to finance "free" mass immunization clinics using state-purchased vaccine, as a result of confusion over the new polio vaccine. (Repeated attempts to incorporate doctors' fees for vaccination into the law itself were defeated on the floor of the House during the debate on H.B. 472, the bill which appropriated $2,000,000 for the State purchase of polio vaccine for "high risk" groups; H.B. 474, died in House Committee on Ways and Means; S.B. 1408, died in Senate Committee on Appropriations.)

—Control of programs for the physically handicapped by an advisory committee within the Department of Labor without any provision for medical representation or counsel. (S.B. 1054, killed by Senate Committee on Labor.)

—A measure legalizing the antiquated "old wives' tale" that epilepsy can be a contributing factor in causing an individual to commit crime. (H.B. 162, killed by the House Committee on Judiciary.)

—An unnecessary hospital licensing act. (H.B. 72, died in House Public Health Committee.)

By the same token, advantageous measures which *succeeded in passing* the Legislature might well have failed, or contained any one of several unsatisfactory provisions, had there not been co-operation by MSMS in supplying authentic factual information, active sponsorship, or co-operation with the Legislature or sponsoring organization. As a result of such interest, the 1955 Legislature successfully took steps which:

—Recognized the contributions to Michigan's historical

and cultural affairs by MSMS members through their restoration of the Beaumont Memorial on Mackinac Island as a gift to the people of this state. (Senate Concurrent Resolution 34, adopted unanimously by both houses of the Legislature.)

—Saved time for the physician by allowing oral prescription of certain narcotics, in line with a recent liberalization of the Federal Law, provided a written prescription is immediately forthcoming. (S.B. 1121)

—Allowed the Basic Science Board to use discretion in waiving examinations for applicants from other states who have already successfully completed examinations in the basic sciences before a licensing board with standards substantially equal to those of the Michigan Basic Science Board, provided the applicant submits a copy of his examination questions and (when in existence) his answers for evaluation by the Michigan Board; an amendment aimed at maintaining Michigan standards of licensure, yet easing the requirements for applicants from non-basic science states. (H.B. 415 carefully amended in each house of the Legislature to allow maximum protection and ease in administration while attempting to alleviate factors which a few believe have tended to discourage M.D.'s from locating in Michigan.

—Raised to $19 per day the ceiling on hospital ward care for crippled and afflicted children. (S.B. 1189 and S.B. 1190)

—Extended from 60 days to 90 days the period for billing for medical treatment of crippled and afflicted children. (S.B. 1120 and S.B. 1162)

—Allowed the use of certain non-caloric sweeteners in the manufacture of foods and beverages, simplifying the problems of patients on special diets. (H.B. 262, passed after amendment based on information from MSMS.)

—Created a new Legislative Advisory Council on Problems of the Aging, which will report annually to the Legislature. (S.B. 1187, responsible to Legislature, adopted in place of S.B. 1128 with narrower range advising Social Welfare Department only.)

Some of the most diligent work during the 1955 Session was done by the Michigan Hospital Association on H.B. 362, with firm support from MSMS. This measure was designed to correct flaws in the County Hospital Act of 1913, discovered by the Supreme Court in its decision on the Gogebic County (Grand View) Hospital case. Although only eight hospitals in Michigan have been set up by counties under the 1913 Act, many side issues were brought up by substandard healing groups, and the possible effects on other hospitals under the precedent established by the Supreme Court was dragged into committee consideration, all of which created confusion. The bill was emasculated in the House with amendments which re-inserted the defects in the law pointed out by the Supreme Court, namely, the provision which limits the authority of the Board of Trustees to adopting rules which govern only the "economic and equitable" conduct of hospitals established under the Act. and denying trustees power over the duties and qualifications of the professional staff. Satisfactory amendments placed on H.B. 362 in the Senate were presented to the House but the House failed to concur in them. A joint conference committee failed to produce a settlement acceptable to the House just before the Legislature recessed on June 3. A second conference committee was appointed to attempt to iron out differences in a report scheduled for submission on July 14, date of final adjournment for the 1955 Legislature. (A supplementary report will be made upon the final outcome of H.B. 362.)

The MSMS Legislative Committee established close liaison with representatives of the Michigan Psychological Association during the year, considering questions of mutual interest.

MSMS also took an active interest in budget and appropriation matters which had a bearing on health, medical education, hospital construction, mental health, and operation of the State Health Department.

Federal legislation also came under the scrutiny of the Legislative Committee throughout the 1955 Congressional session, and the MSMS viewpoint on Federal matters was kept constantly before the Michigan congressional delegation by direct contact, and to the Congress as a whole by contact with the AMA Washington office. An MSMS delegation visited Washington in early May for on-the-spot conferences with Michigan congressmen and senators and other congressional leaders.

In summarizing Lansing events of the past few months, it should be pointed out that members of both houses of the Legislature, regardless of political party, were most attentive to MSMS representatives, often voluntarily seeking the advice of the Society in matters pertinent to health and medicine. Most legislative decisions, whether favored by MSMS or not. were made with all necessary information in the hands of legislators. Relationships with the Governor and, in his absence, the Lieutenant Governor, were particularly cordial throughout the 1955 Legislature and the "front office" frequently requested the MSMS viewpoint on various matters.

The Legislative Committee further recognizes that success of MSMS legislative activities during the 1955 session was once more the result in a large part, of the interest and activity of a great many members of MSMS; those who shouldered the burden by personally taking an active part on the local level, or who had a hand in the decisive group action taken by county medical societies. Some of the most effective work in behalf of the people of Michigan is done in the home community by the county society and individual Doctor of Medicine between sessions of the Legislature. Increasingly, county society leaders are making an effort to become well-acquainted with local legislators and to establish a working relationship with them.

This is the type of activity which must be planned carefully and carried out conscientiously at the community level before the Legislature convenes once more in January, 1956.

To all MSMS members who have during 1954-1955 contributed their time, energy, counsel, and suggestions toward the success of the MSMS legislative program, we are sincerely grateful. We appreciate their sacrifices. They deserve the heartfelt thanks not only of their colleagues, but of all the citizens of Michigan.

Respectfully submitted,
L. A. Drolett, M.D., *Chairman*
O. B. McGillicuddy, M.D., *Vice Chairman*
William Bromme, M.D.
G. V. Conover, M.D.
J. C. Elliott, M.D.
O. K. Engelke, M.D.
L. W. Hull, M.D.
W. S. Jones, M.D.
M. H. Marks, M.D.
P. T. Mulligan, M.D.
J. S. Rozan, M.D.
H. A. Towsley, M.D.
R. V. Walker, M.D.

ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE, 1954-1955

This report briefly summarizes the activities of several of the Advisory Committees during the past year.

The Rheumatic Fever Control Committee continues in its basic function as an educational source for both practicing physicians and the public. Desk reference cards on Rheumatic Fever are being distributed periodically, model county programs are being set up in collaboration with health officers, and teaching facilities for cardiac children are in process of development in cooperation with the Michigan Department of Public Instruction. The plan of sending several physicians to

St. Francis Sanatorium each year for refresher courses in Rheumatic Fever is continuing as in the past.

The Maternal Health Committee continues its survey of maternal deaths and the results of the first three years' study have been published in a recent number of THE JOURNAL of the Michigan State Medical Society.

The Venereal Disease Control Committee studied the problem of prophylaxis for gonorrheal ophthalmia neonatorum and has recommended the substitution of 1 per cent penicillin ointment for 1 per cent silver nitrate. It also urged that the Treponema Pallidum Immobilization test be made available by the State Laboratory to doctors with special problems of syphilis or biological false positive reactions.

Modifications of the pre-marital examination certificate were recommended.

The Mental Health Committee's activities were directed towards the problem of lay-psychotherapy, the relationship between physicians and psychologists and a furthering of the educational program for both lay and professional groups.

The Iodized Salt Committee continues to promote the more widespread use of iodized salt by placarding grocery stores and educating wholesale grocers; by exhibits at State Medical Society meetings; by publication of timely articles in important magazines; and by stimulating surveys in communities outside of Michigan. The study of goiter operations performed in Michigan is being completed and will be reported in the near future.

The Scientific Radio Committee, in planning to broaden its audience of 50,000 school children, has arranged to expand the membership of its subcommittee to include both lay and professional people prominent in this work. In addition to appropriate subject matter the committee has made every effort to have program topics coincide with national health weeks and specific health days.

The Committee on Postgraduate Medical Education's program has been well received throughout the state. Plans are under way to include the subject of periodic health examinations in its extramural program.

Appreciation is due our State Health Commissioner, Dr. A. E. Heustis and Dr. J. K. Altland for their active participation in the deliberations of this committee and for their valuable suggestions, guidance and help.

Respectfully submitted,

W. S. REVENO, M.D., *Chairman*
G. E. ANTHONY, M.D.
H. W. BIRD, JR., M.D.
B. E. BRUSH, M.D.
H. H. CUMMINGS, M.D.
A. C. CURTIS, M.D.
S. T. HARRIS, M.D.
A. E. HEUSTIS, M.D.
W. A. HYLAND, M.D.
O. J. JOHNSON, M.D.
A. H. PRICE, M.D.
P. E. SUTTON, M.D.
J. W. TOWEY, M.D.
H. A. TOWSLEY, M.D.

ANNUAL REPORT OF VENEREAL DISEASE CONTROL COMMITTEE—1954-1955

During the past year a meeting was held on February 20, 1955, at which time it was proposed that examinations on migratory agricultural workers who come into the seven counties of the Saginaw Valley (Huron, Tuscola, Sanilac, Bay, Saginaw, Midland and Isabella) be screened by chest x-ray, STS and physical examination of males.

The Method of Operation is to be as follows:

I. Using mobile trailers and moving from farm to farm, chest x-rays, blood drawing for STS, and physical examinations of all males will be affected. Working hours will be from 6:00 to 10:00 p.m. A clerk will register all persons. A technician will be employed to draw bloods and a qualified physician will make a physical examination of the genitalia of all males. Those males with evidence of urethral discharges will be treated. Blood samples will be sent to the nearest state laboratory where we hope to receive results back within 72 hours.

II. Treatment:

(a) Syphilis—all persons having a positive blood will be treated by the project physician with 2,500,000 units of Bicillin. At the time of treatment a second blood will be drawn. A diagnosis of syphilis, in absence of clinical evidence, will not be made unless this second STS is positive. All persons with clinical evidence will be treated with 2.5 million units.

(b) Urethritis—All males having urethral discharge will receive 1.2 million units of Bicillin.

III. Epidemiology:

(a) Syphilis—Persons with clinical evidence of syphilis will be interviewed and attempts made to bring contacts to diagnosis and treatment.

(b) Urethritis—All males with urethritis will be interviewed and attempts made to bring contacts to diagnosis and treatment.

The Venereal Disease Control Committee heartily approved of the principle of the pilot study and expressed interest in what the results should show.

After some discussion of the use of Bicillin, the Committee recommended that the present schedule of procaine penicillin be considered the treatment of choice for management of all types of syphilis; however where an emergency exists and multiple injections cannot readily be given, the Committee approves that Bicillin be used as a substitute as a single injection of 2.4 to 3 million units but also recommends where co-operation for additional treatment can be secured that an additional injection be given one week later; carried unanimously.

Dr. Shaffer led a discussion on the increase in number of cases of gonorrhea being reported and showed slides on statistics in the City of Detroit and in his clinic. There are evidences of increase in gonorrheal ophthalmia neonatorum. The statistics show that gonorrhea is on the increase and suggested that the following might be some of the causes: (a) increase in juvenile delinquency; (b) deteriorating moral standards; (c) less fear of infection; and (d) inadequate treatment by oral penicillin.

Respectfully submitted,

A. C. CURTIS, M.D., *Chairman*
J. A. COWAN, M.D.
RUTH HERRICK, M.D.
D. K. HIBBS, M.D.
H. L. KEIM, M.D.
H. E. LICHTWARDT, M.D.
J. A. RYAN, M.D.
L. W. SHAFFER, M.D.
D. E. SILER, M.D.
FRANK STILES, M.D.
R. S. BREAKEY, M.D.

Nitrogen mustard is only moderately effective in leukemia, but is of great value in Hodgkin's disease.

* * *

Folic acid antagonists produce more satisfactory results in acute leukemia in children than in adults.

* * *

X-ray therapy is a superior form of treatment in multiple mycloma and chronic granulocytic leukemia.

* * *

External radiation is the method of choice in treatment of Ewing's sarcoma.

Technical Exhibits -- 1955 Annual Session

Abbott Laboratories **Booth No. 408**
North Chicago, Illinois

Filmtab® ERYTHROCIN® Stearate (Erythromycin Stearate, Abbott) will be displayed by Abbott Laboratories. ERYTHROCIN gives specific therapy against coccic infections . . . and with little risk of side effects. It's especially advantageous when the cocci resist other antibiotics. Indications include pharyngitis, bronchopneumonia, tonsillitis, cellulitis, otitis media, furunculosis, sinusitis, laryngitis, bronchitis, lobar pneumonia, scarlet fever, peritonsillar abscess, erysipelas, septic sore throat, pyoderma, urinary tract infection, wound infection and acute and chronic intestinal amebiasis.
®Filmtab—Film sealed tablets; patent applied for.

A. S. Aloe Company **Booth No. P-26**
St. Louis, Missouri

Visit Space No. P-26 where the A. S. Aloe Company will have on display a cross-section of their most complete line of physicians' supplies. Our representatives will certainly appreciate the opportunity of discussing items of interest with you.

American Ferment Company, Inc. **Booth No. 112**
New York, N. Y.

Representatives at the booth will welcome the opportunity to demonstrate the proteolytic and mucosolvent action of the enzyme, Caroid, and to discuss Caroid and Bile Salts Tablets and Alcaroid Antacid. Supligol, a whole bile-ketocholanic acid compound useful in the management of biliary dysfunction, will also be featured.

American Hospital Supply Corporation **Booth No. 619**
Evanston, Illinois

On exhibit will be the complete line of Baxter Intravenous Solutions including new Travert Solutions, new Plexitron Sets for parenteral therapy and new blood pumps for rapid blood transfusions. See the new FLASHBALL which simplifies needle insertion and addition of supplemental medication.

Ames Company, Inc. **Booth No. 414**
Elkhart, Indiana

The Ames representatives Messrs. Roger Gosling and Ralph Matheny will be on hand to discuss MY-B-DEN, the adenine nucleotide, adenosine-5-monophosphate, found highly effective in the treatment of varicose vein complications, stasis and bursitis. MY-B-DEN preoperatively shortens the waiting period necessitated by poor tissue condition and enhances surgical results. DECHOLIN/Belladonna will also be shown.

Armour Laboratories **Booth No. 104**
Kankakee, Illinois

The Armour Laboratories booth will feature H. P. Acthar Gel as well as other specialties of Armour Research. Our representatives will be happy to answer questions about Armour products for anyone who cares to stop at our booth.

Audio-Digest Foundation **Booth No. 609**
Glendale, California

Audio-Digest Foundation—a subsidiary of the California Medical Association—gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast"—compiled and reviewed by a professional Board of Editors—may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

Ayerst Laboratories **Booth No. 412**
Chicago, Illinois

Your Ayerst Representatives cordially invite you to visit them at Booth No. 412 where they will be glad to discuss any Ayerst products of interest. The Ayerst Exhibit will feature "Colprosterone," Progesterone Vaginal Tablets, and "Mediatric" Capsules and Liquid for your geriatric patients.

Baby Development Clinic **Booth No. P-1**
Chicago, Illinois

Maternity Counselling Service offers: Products and literature helpful in teaching expectant mothers (and fathers) physical and emotional aspects of parent-child relationship arising out of daily care in feeding, bathing, sleeping and toileting. Aids for parents to understanding and providing emotional security for children through school ages.

Baker Laboratories, Inc. **Booth No. 504**
Cleveland, Ohio

You are invited to visit our booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.
Baker representatives will be glad to discuss the practical application of Grade A Milk, adjusted fat composition, zero curd tension, synthetic vitamins and other important factors which help to eliminate many of the problems in modern infant feeding.

Bard-Parker Company, Inc. **Booth No. 205**
Danbury, Connecticut

RACK-PACK . . . gross and half gross units of B-P Rib-Back Surgical Blades ready for sterilization in a matter of seconds. Saves time and labor in the O.R., prevents costly, accidental damage to sharp edges. B-P knife handles, B-P Germicide, Chlorophenyl, sterilizing containers, transfer forceps, "C.F." Pipettes, B-P Disposable Finger Lancets, and the Reese Dermatome.

Barry Laboratories, Inc. **Booth No. 317**
Detroit, Michigan

The BARRY LABORATORIES will exhibit complete, easy-to-use allergy diagnostic sets and treatment materials. Also on display will be their new germicidal concentrate, Merphene, as well as a complete line of sterile injectables. An attendant will be present to answer questions regarding any of the items exhibited.

Beech-Nut Packing Company **Booth No. 520**
New York, New York

The Borden Company **Booth No. 305**
New York, New York

There's no better place to talk over the latest information on infant feeding than the Borden Prescription Products booth. On display is the complete line of Borden's infant formula products for every feeding purpose or preference. You can feed almost any baby BREMIL, MULL-SOY (Liquid or Powdered), DRY-CO, or BIOLAC.

Bristol-Myers Products Division **Booth No. 613**
New York, New York

Here are four products you'll want to know about: BUFFERIN—Antacid analgesic. Acts twice as fast as aspirin, does not upset the stomach. SAL HEPATICA

—Effervescent saline laxative. AMMENS Medicated Powder—Relieves itching and burning skin. Discourages bacterial growth. TRUSHAY—The "beforehand" lotion. Helps keep hands smooth in spite of roughening scrubbings.

Brooks Appliance Company **Booth No. 314**
Chicago, Illinois

The Brooks Appliance Company will exhibit and describe in detail the technique of applying the combination pressure bandages. The moist medicated Primer Bandage plus the Dalzoflex Elastic Adhesive Bandage which are used in treating leg ulcers and Phlebitis. Elastic Stockings, the Nulast Elastic Crepe Bandages and Surgical Instruments will also be displayed.

Burroughs Wellcome & Company **Booth No. 420**
Tuckahoe, New York

The extensive research facilities of "B. W. & Co." both here and in England are directed to the development of improved therapeutic agents and techniques.
Through such research "B. W. & Co." has made notable advances related to cancer, malaria, diabetes, antibiotics, muscle relaxants, and autonomic, antihistaminic, and antinauseant drugs.
An informed staff will be at our booth to discuss our products and latest developments.

Cambridge Instrument Company, Inc. **Booth No. 514**
New York, New York

The new Cambridge Audio-Visual Heart Sound Recorder; the well-known Cambridge Simpli-Scribe Model Direct-Writing Portable Electrocardiograph and the Cambridge Standard String Galvanometer Electrocardiograph, both in the "Simpli-Trol" Portable and the Mobile Model Electrocardiograph-Stethograph with Pulse Recorder, will be displayed at this booth. Also, other important Cambridge instruments, including the Operating Room Cardioscope, Educational Cardioscope, Multi-Channel Direct-Writing Recorder, Electrokymograph, Plethysmograph, and pH Meters. The Cambridge Engineers in attendance will be glad to give you complete information on these instruments.

Cameron Surgical Specialty Company **Booth No. P-15**
Chicago, Illinois

Visit the interesting and informative Cameron exhibit of integrated diagnostic instruments, incorporating the focalite system which assures maximum illumination, service and satisfaction at minimum cost. Also the new Cameron Cauteradiodyne, incorporating cauterization, coagulating, fulguration, desiccation, dehydration, and orificial ultra-violet radiation; and other diagnostic and operative aids and specialties.

Carnation Company **Booth No. 505**
Los Angeles, California

Carnation Company is pleased to present the first INSTANT Nonfat Dry Milk. You are cordially invited to visit with us and to sample this miracle product . . . the greatest advance in the dairy industry since homogenization. You'll like its fresh milk flavor . . . it dissolves instantly, even in ice water. An excellent, economical source of protein; useful in diets for weight reduction, high protein, undernutrition, pregnancy and geriatrics.

Central Pharmacal Company **Booth No. 513**
Seymour, Indiana

The Central exhibit will feature the Neocylate Family of potentiated salicylate combinations.
This group includes five products which may be prescribed successfully for the prevention and treatment of pain of varying intensity and origin in all types of arthritic and rheumatic conditions.
Descriptive literature and samples will be available to members and guests of the Michigan State Medical Society.

Chicago Pharmacal Company **Booth No. 508**
Chicago, Illinois

Chimedic quality products featured include: URISED, nationally-known urinary antiseptic and sedative tablet; TOLYPHY, the improved spasmolysis formula for a wider range of muscle relaxation; VERMIZINE, the deliciously strawberry-flavored vermifuge, 97 per cent effective in the eradication of pinworms in children; CEVICETYL, full therapeutic combination of aspirin and Vitamin C in an enteric coated tablet; plus a complete injectable, ointment, liquid and tablet line awaiting your inspection. Representatives: Mr. M. C. Miner, Mr. C. G. Shotwell.

Chicago Reference Book Company **Booth No. P-22**
Chicago, Illinois

Ciba Pharmaceutical Products, Inc. **Booth No. P-3**
Summit, New Jersey

The CIBA exhibit features SERPASIL—the original, pure crystalline alkaloid of Rauwolfia. SERPASIL has been found extremely useful as a tranquilizer in treating patients whose adjustment to life is complicated by anxiety, irritability and various psychoses. Patients feel calm, yet in properly adjusted doses retain their drive and energy. It is highly effective in many conditions where barbiturates have been commonly prescribed.

Coca-Cola Company **Booth Nos. P-9, P-10**
Atlanta, Georgia

Ice-cold Coca-Cola served through the courtesy and co-operation of the LaSalle Coca-Cola Bottling Company, Grand Rapids, and The Coca-Cola Company.

DePuy Manufacturing Company **Booth No. 605**
Warsaw, Indiana

We extend an invitation to all members of the Michigan State Medical Society to visit us at our booth where we will exhibit the new Scuderi Hip Prosthesis, Small Hand Drill, Plate Bending Irons, Spring Retractors, Bone Screw Rack, Pelvic Traction Apparatus and our complete line of orthopedic and fracture equipment. Stop in and see us at Booth 605.

Desitin Chemical Company **Booth No. 416**
Providence, Rhode Island

DESITIN OINTMENT: the pioneer in external cod liver oil therapy.
Indications: diaper rash, slow healing wounds, burns of all degrees, lacerations, hemorrhoids and fissures.
DESITIN POWDER: a unique, dainty medicinal powder saturated with cod liver oil.
DESITIN HEMORRHOIDAL SUPPOSITORIES with COD LIVER OIL: coats ano-rectal area with soothing, lubricating cod liver oil, gives prompt relief of pain, allays itching.
DESITIN LOTION: The original cod liver oil lotion, soothing, protective, mildly astringent and healing, in non-specific dermatitis, pruritus, poison ivy, etc.

Dictaphone Corporation **Booth No. 212**
Detroit, Michigan

For busy doctors—Dictaphone Corporation presents the Time-Master dictating machine. Also try the Time-Master Telephone Recording and the new President Model with Remote Power Control. Power Control centralizes all dictating operations on the hand microphone itself.
For hospitals—medical records are more complete and more accurate with the Dictaphone Telecord System of network dictation by phone.

Dietene Company **Booth No. 401**
Minneapolis, Minnesota

Have YOU tasted MERITENE . . . the whole protein supplement that DOES taste good? Visit our booth, enjoy a MERITENE Milk Shake with its multiple nutritive values.
While you're there, review the Dietene Diet based on DIETENE Reducing Supplement. It provides the rare combination of low calories (1000) with high intake of protein and all essential vitamins and minerals in an interesting, effective, SAFE weight-reducing diet.

Doho Chemical Corporation **Booth No. 415**
New York, New York

Doho Chemical Corporation is pleased to exhibit:
AURALGAN, the ear medication for the relief of pain in Otitis Media and removal of Cerumen;
NEW OTOSMOSAN, the effective, non-toxic ear medication which is Fungicidal and Bactericidal (gram negative-gram positive) in the suppurative and aural dematomycotic ears;
RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged.
Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation, is also featuring:
RECTALGAN, the liquid topical anesthesia, also for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

Eaton Laboratories, Inc. **Booth No. 103**
Norwich, New York

For prompt results in urinary tract infections, Furadantin® is now available in the form of tablets and as Furadantin Oral Suspension.
The latest dosage forms of Furacin® of special interest include Furacin Vaginal Suppositories for cervicitis and vaginitis, Furacin Urethral Suppositories for painless therapy of urethritis, and Furaspor® Cream for rapid control of dermatomycoses.
For the treatment of Trichomonas vaginalis vaginitis and the accompanying secondary bacterial infections, we now have available Tricofuron* Vaginal Suppositories and Powder.
*T.M.

Paul B. Elder Company **Booth No. 509**
Bryan, Ohio

Members of the Society and their guests are cordially invited to visit Booth No. 509. A new drug for the treatment of idiopathic vitiligo, as well as several other interesting and new pharmaceuticals, will be presented.

Encyclopedia Americana **Booth No. 313**
Grand Rapids, Michigan

We will feature our 1955 edition of *Encyclopedia Americana.* The finest and best in our 126-year history acclaimed by leading educators as the ultimate for reference. All those who register at our booth will receive a 48-page world atlas in full color.

Ethicon Suture Laboratories **Booth No. 110**
New Brunswick, New Jersey

Ethicon CP Surgical Gut and Textile Sutures
Ethicon Atraloc Eyeless Needle Sutures
Bio-Sorb Absorbable Dusting Powder
Gamophen Antiseptic Surgical Soap
Tantalum Gauze and Other Tantalum Surgical Materials
SUTUPAK—Pre-cut Sterile Surgical Silk and Cotton Sutures
Surgical Steel Sutures and Gauze
Surgiset, Surgiset, Sr., and Pocket Surgiset—Suture Assortments
LIGAPAK—Spiral Wound Sutures
New OPHTHALMIC Sutures

Executone Company of Detroit **Booth No. 114**
Detroit, Michigan

At the Executone booth there will be "live" demonstrations of Executone's latest electronic intercummunication systems engineered and designed for use by the physician in his private offices, or in clinics and medical centers. Doctors will be shown how these communication systems save doctor's precious time and energy, help him see more patients each day, help him and nurse run office more efficiently and with less effort.

M. G. Farnsworth & Company and **Booth No. 318**
Waite Pharmacal Company, Inc.
Chicago, Illinois

Presenting:

DYPRO . . . The non-narcotic, non-steroid analgesic, antipyretic and anti-rheumatic. Normally, complete relief from pain is anticipated within minutes following injections. Patients remain awake and able to co-operate.
AQUACAINE . . . The prolonged local anesthetic.
KOLMET . . . Widely used in mixed infections and brucellosis.
THE WAITE PROGRAM . . . For the treatment of obesity, excessive weight considered as a health problem.

H. G. Fischer & Company **Booth No. 518**
Detroit, Michigan

Latest models of Modern X-ray, F.C.C. approved Physicial Medicine and Rehabilitation Equipment, all of highest quality materials and construction, will be on display. Representatives in attendance will welcome an opportunity to give demonstrations and quote today's low prices. Your visit will be appreciated.

C. B. Fleet Company, Inc. **Booth No. 519**
Lynchburg, Virginia

During the past fifty years PHOSPHO-SODA (FLEET) has been a symbol of elegance in sodium phosphate medication. FLEET ENEMA DISPOSABLE UNIT—an enema solution of Phospho-Soda (Fleet)—is a worthy companion product. The single use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema it is a boon to the hospitalized patient.

Flint, Eaton & Company **Booth No. 316**
Decatur, Illinois

Flint, Eaton presents Ferrolip, a new chelate complex of iron.
Chelated iron, as in Ferrolip, is resistant to all usual chemical forces serving to precipitate iron and to produce iron intolerance; yet the chelated iron in Ferrolip is completely soluble and readily available for uptake along the entire gastrointestinal tract.
Visit the Flint, Eaton & Company booth to hear of chelation as it applies to iron therapy.

E. Fougera & Company, Inc. **Booth No. 512**
New York, New York

E. FOUGERA & COMPANY, INC., and Division, VARICK PHARMACAL COMPANY, INC., cordially invites physicians to discuss with Professional Service Representatives new preparations of importance to their every day practice. Descriptive literature and samples of all products will be available.

Freeman Manufacturing Company **Booth No. 102A**
Sturgis, Michigan

Makers of Orthopedic Supports

For more than sixty years, Freeman has been engaged in making surgical supports and elastic hose. During that time we have worked closely with members of the medical profession. Their assistance has proved invaluable in enabling us to maintain the highest standards of quality and design.

Geigy Pharmaceuticals **Booth No. 208**
New York, New York

GEIGY will feature Council Accepted BUTAZOLIDIN, oral nonhormonal antiarthritic, and MEDOMIN, new hypnotic-sedative affording sound, refreshing sleep and alert awakening without hangover. Also on display will be EURAX Cream and Lotion, antipruritic and scabicide; TROMEXAN, oral anticoagulant of rapid action, little cumulation and diminished risk of sustained or severe hemorrhage; and STEROSAN Cream and Ointment, bacteriostatic and fungistatic for treatment of pyogenic and mycotic skin disorders.

General Electric Company **Booth No. P-19**
Milwaukee, Wisconsin

X-Ray Department, General Electric Company, manufacturers of complete X-Ray equipment from portable diagnostic to 2,000,000-volt therapy apparatus — electrocardiograph—diathermy—X-Ray accessories and supplies. Whatever your needs, you can put your confidence in General Electric.

Gerber Products Company **Booth No. 319**
Fremont, Michigan

WHEN MILK IS CONTRAINDICATED as the basic food for infants, Gerber's "Meat Base Formula" can provide a nutritionally adequate replacement. It is well accepted and tolerated by infants of all ages. Your Gerber detailman invites you to evaluate "Meat Base Formula" and the complete line of supplementary baby foods.

Grand Rapids Creamery Company **Booth No. P-7**
Grand Rapids, Michigan

Sealtest TRADE MARK DAIRY PRODUCTS

Grand Rapids Creamery Co., local distributors of Sealtest milk, ice cream, and dairy products invites you to stop at their booth displaying the Sealtest symbol of quality, and enjoy a complimentary bottle of Sealtest milk. Representatives will be on hand to answer your questions on dairy products.

Hack Shoe Company **Booth No. P-11**
Detroit, Michigan

Regular as well as prescription shoes.

J. F. Hartz Company **Booth No. 116**
Ferndale, Michigan

Cardiovascular, thoracic, eye, and general surgery stainless steel instruments; diagnostic equipment; and our latest pharmaceutical specialty, will be on display in the booth of The J. F. Hartz Company at the Michigan State Medical Exhibition of 1955.

H. J. Heinz Company **Booth No. 214**
Pittsburgh, Pennsylvania

Heinz offers your infant and adult patients on soft diets over 60 varieties of Strained and Junior Foods, including 100% meats now completely in glass.
The four Heinz Pre-Cooked Cereals—Barley, Oatmeal, Rice and Cereal Food are now in packages with the new pouring spout.
A new Teething Biscuit of novel horse shoe shape, crumble proof and moderately sweet, which has been fortified with Iron and the B vitamins, is a brand new item in the line.
The following literature is available: For the physicians the Revised (1954) edition of Nutritional Data, Variety and Ingredient Listing Pads and Prescription Pads. For the patient these booklets: Facts about Foods, Feeding Guide for Healthy Happy Babies and Recipe Magic.

Hoffmann-La Roche, Inc. **Booth No. 215**
Nutley, New Jersey

NODULAR is a new, *non-barbiturate* hypnotic which provides effective relief of insomnia and tension states. NOLUDAR is so well tolerated that side effects such as nausea, vomiting, and dizziness, are rarely, if ever, experienced with therapeutic doses. NOLUDAR is available in scored tablets of two strengths, 50 mg and 200 mg, and in a cordial-flavored elixir, 50 mg per teaspoonful.

Holland-Rantos Company, Inc. **Booth No. 101**
New York, New York

Physicians interested in Medical Contraception are invited to discuss with H-R representatives latest information on laboratory and clinical data concerning efficacy of Koromex products. . . . Trichomonicidal, fungicidal and bactericidal Nylmerate Jelly and Solution and the Dila-Spray will also be shown, as will the new Hollandex Ointment.

G. A. Ingram Company **Booth Nos. 407, 409, 411**
Detroit, Michigan

THE G. A. INGRAM COMPANY will include in its exhibit this fall, the latest in equipment: diagnostic and surgical instruments, as well as physical therapy and laboratory supplies. A number of their men will be on hand to give you immediate attention, and they will appreciate your dropping by to see them.

Instant Sanka Coffee **Booth Nos. P-16, P-17**
White Plains, New York

It is gratifying to General Foods to be associated with the Ninetieth Annual Session of your Society. INSTANT SANKA will be served daily. This is 100% pure coffee, with 97% of the caffein removed. We invite you to sample this delicious coffee often during the Session, and to register for a professional sample and product booklet.

Jobst Applied Biomechanics Institute **Booth No. 502**
Toledo, Ohio

Jobst Applied Biomechanics Institute invites you to visit the scientific exhibit on the principle of hydrostatic counter pressure to stimulate fluids dynamics in limbs. Details of technical essentials necessary for the creation of a functioning support are clearly demonstrated.

E. J. Kantar Company **Booth No. 115**
Detroit, Michigan

E. J. Kantar Company, 2575 Puritan Avenue, Detroit, Michigan—Michigan's oldest and most complete intercommunication and signaling headquarters —Webster Electric Teletalk intercommunication systems; Golden Tone Ekotape recorders; Amplifiers, preamplifier-equalizers for background high fidelity music and public address systems.

C. B. Kendall Company **Booth No. 506**
Indianapolis, Indiana

In accordance with a custom which approaches the status of tradition, we will of course be represented at the September Meeting of the Michigan State Medical Society.

We appreciate this opportunity to again present the several Kendall products which your members have found so worthy of their acceptance.

Kremers-Urban Company **Booth No. 601**
Milwaukee, Wisconsin

WELCOME TO THE KREMERS-URBAN EXHIBIT. Medications featured: LEVSIN Sulfate, the most potent antispasmodic for relief of visceral muscle spasm; NITROL Tablets and Ointment for prophylaxis against anginal attacks provides both fast and prolonged vasodilatation; SALIMEPH-C and PHYATROMINE-H "inject-oral" combination for relief of crippling skeletal muscle spasm.

A. Kuhlman & Company **Booth No. 417**
Detroit, Michigan

The A. Kuhlman & Company of Detroit invites you to see our exhibit of the latest colors in steel and wood examining room furniture. Also on display will be many new diagnostic and surgical instruments.

Lea & Febiger **Booth No. 102**
Philadelphia, Pennsylvania

Be sure to see these 1955 books: Pullen—Pulmonary Diseases; Twiss and Oppenheim—Practical Management of Disorders of the Liver, Pancreas and Biliary Tract; Herbut—Pathology; Bailey—Surgery of the Heart; Goldberger—Heart Disease; Master, Moser and Jaffe—Cardiac Emergencies and Heart Failure; Burch and Winsor—Primer of Electrocardiography; Epstein—The Spine; Ritvo—Bone and Joint X-Ray Diagnosis; Merritt—Neurology; and other books of current clinical importance.

Lederle Laboratories **Booth No. P-25**
Pearl River, New York

You are cordially invited to visit our exhibit in booth P-25 where you will find our representative prepared to give you the latest information on LEDERLE products.

Liebel-Flarsheim Company **Booth No. 207**
Cincinnati, Ohio

The Liebel-Flarsheim Company cordially invites you to visit Booth 207, in which their latest electromedical-electrosurgical equipment will be exhibited. We ask particularly that you stop and see the L-F Basal-MeteR, the first automatic, self-calculating metabolism unit ever offered. Capable representatives will be on hand at all times.

Eli Lilly & Company **Booth Nos. 204, 206**
Indianapolis, Indiana

You are cordially invited to visit the Lilly exhibit located in space numbers 204 and 206. The display will contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

J. B. Lippincott Company **Booth No. P-4**
Philadelphia, Pennsylvania

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

M & R Laboratories, Inc. **Booth No. 405**
Columbus, Ohio

Your SIMILAC representatives are happy to take part in this meeting. They are pleased to have the opportunity to discuss with you the role of SIMILAC in infant feeding. They have for you the latest Pediatric Research Conference Reports. Also available are current reprints of pediatric nutritional interest.

Maico Company, Inc. **Booth No. 507**
Grand Rapids, Michigan

MAICO products (Medical Acoustic Instrument Co.) are well known to the medical profession. Their audiometers and hearing aids are unexcelled for excellence in precision and reliability in giving service to their users.

Ninety per cent of all precision hearing test equipment used in the United States by doctors, hospitals, schools, clinics, et cetera, are supplied by the Maico Company, Inc.

Maltbie Laboratories Division **Booth No. 108**
Wallace & Tiernan, Inc.
Belleville, New Jersey

You are cordially invited to visit the Maltbie Exhibit. Featured items will be DESENEX, the well-known undecylenate fungicide; SALUNDEK, for Tinea Capitis; MALCOTRAN, the high potency, low dosage anticholinergic; CHOLAN-HMB, for biliary dysfunction and SOTRADECOL, for safe, effective injection therapy of varicose veins and internal hemorrhoids.

S. E. Massengill Company **Booth No. P-18**
Bristol, Tennessee

The S. E. Massengill Company will feature SALCORT, the new antiarthritic with multiple advantages. Combined, Salicylates multiplied while the side effects are reduced. SALCORT provides safe, dependable relief in arthritic affections. Early functional improvement and a sense of well being are significant in a large number of patients.

McNamara Medical Equipment Company **Booth No. 403**
Detroit, Michigan

We will exhibit the finest in ultra-sonic generators, electrical muscle stimulators, moist steam packs, and other allied physical medical equipment.

We shall be happy to discuss with you any equipment problem you may have.

Mead Johnson & Company **Booth No. 320**
Evansville, Indiana

New displays of Liquid Lactum and Powdered Lactum, complete infant formulas, will be featured at the Mead exhibit. Also on display will be Liquid Sobee, the hypoallergenic soya formula, Sustagen, the complete food, and Natalins, the smaller prenatal capsule.

Medco Products Company **Booth No. P-6**
Tulsa, Oklahoma

Medical Arts Physiotherapy Equipment Co.
Detroit, Michigan **Booth No. 511**

John C. Hesse, representative for the Hanovia Chemical Mfg. Co. for thirty years, is now in business for himself, supplying a complete line of Electro Medical Specialties. Such as Short Wave Diathermy, Ultra Violet and Infra Red lamps, Muscle Stimulators and Ultra Sound generators.

Medical Arts Supply Company **Booth Nos. 309, 311**
Grand Rapids, Michigan

Medical Arts' Boys will again occupy their familiar spot—Nos. 309, 311.

They will display medical furniture, instruments, diagnostic equipment, physical therapy units, medical supplies and pharmaceuticals.

Representatives from the entire state will be on hand to greet you.

Please stop at Booths 309 and 311.

Medical Protective Company **Booth No. 117**
Fort Wayne, Indiana

An unparalleled record of successful malpractice protection since 1899 distinguishes The Medical Protective Company from all others. Year in and year out 99.94 per cent of its policyholders have been completely covered under $2,500. It's a sustained record that causes Medical Protective to be considered the Doctor's most secure source of security.

Wm. S. Merrell Company **Booth No. 210**
Cincinnati, Ohio

The Wm. S. Merrell Company presents Bentyl, the safe, effective, yet comfortable antispasmodic that is superior to atropine and belladonna for relief of nervous indigestion.

Bentyl has a musculotropic action like that of papaverine, and a neurotropic action like that of stropine. Because of its unique specificity for the G. I. tract, Bentyl is virtually free of the side effects generally associated with antispasmodics, and offers effective relief without "belladonna backfire."

Literature, including reprints reporting more than 1,500 clinical cases treated with Bentyl, is available at the booth.

Meyer Chemical Company, Inc. **Booth No. 109**
St. Clair Shores, Michigan

Gastralme, and antacid, and Almethine, a time disintegration capsule Expoxymethamine Bromide, a highly effective parasympatholytic drug in the suppression of acid secretion and gastric hypermotility when administered orally. Almethine Duracaps produce an effect lasting about 12 hours.

Michigan Cooperative Surgical Supply Co., Inc. **Booth No. 111**
Grand Rapids, Michigan

The Michigan Cooperative Surgical Supply Co. carries a complete line of quality equipment and supplies for the physicians and surgeons of Michigan. Our guarantee is your complete satisfaction at all times. Our aim is service.

Michigan Medical Service **Booth No. 304**
Detroit, Michigan

The Blue Shield exhibit exemplifies the prepayment plan sponsored by the doctors of Michigan and what that plan means to the people of the State. The family scene is typical of a family which has been relieved of the worry of catastrophic medical bills.

The photograph of the doctor and the child which makes up the Blue Shield portion of the exhibit is symbolic of the co-operation of the doctors of Michigan. Through that co-operation, Blue Shield in Michigan has led the nation in meeting the needs of the public.

Middleton's Incorporated **Booth No. 517**
Grand Rapids, Michigan

It's here—at Middleton's
Ar-Ex Cosmetics
America's finest hypo-allergenic Cosmetics and Dermatological Pharmaceuticals
* Clinically tested on allergic persons
* For use by allergic persons
* Available scented and unscented
* As glamorous as they are safe

Mr. Peter Middleton will be in attendance to show and present samples of all these products for your inspection and approval.

Miles Reproducer Company, Inc. **Booth No. 510**
New York, New York

Case histories, lectures and dictation may now be recorded at a 60-foot radius with Walkie-Recordall, an 8-lb. self-powered battery recorder-transcriber. It operates in or out of the closed briefcase, indoors or outdoors, while stationary, walking, riding or flying. The Voice-Activated Self-Start-Stop feature automatically starts and stops the recording from microphone or telephone, thus eliminating supervision and the recording of silent periods. While facilities for transcribing are available, transcription may be eliminated due to ease of handling identifiable, compact, indexed recordings without the delay of rewinding. Up to 8 hours of permanent recordings may be accumulated at intervals on an "endless" belt costing 25 cents.

Miller Surgical Company **Booth No. P-24**
Chicago, Illinois

MILLER SURGICAL COMPANY will show the Miller Electro-scalpel. This unit cuts, desiccates, fulgurates, coagulates, and is used for most delicate work up to light major surgery. Accessories such as Snares, Smoke Ejectors, et cetera also available. A complete line of Diagnostic Equipment consisting of Illuminated Otoscopes, Ophthalmoscopes, Eyespud with magnet, Transillumination Lamps, Headlights, Vaginal Speculum with Smoke Ejector and the Gorsch Operating Scopes and Stainless Steel Proctoscopes all sizes with magnification, Suction Tubes, and Grasping Forceps.

Muller's Shoes, Inc.
Grand Rapids, Michigan **Booth No. P-12**

Specializing in orthopedic type footwear for juveniles and adults. Our stock includes various special shoes such as Sabel club foot shoes, surgical, pre-walker, surgical and slub, and pigeon toe shoes. Also Tarso Supernator (flat foot) and Pronator (pigeon toe) and "Nature's Own," 100 per cent straight last shoes. We also have a complete mismating service.

Nepera Chemical Company, Inc. **Booth No. 211**
Yonkers, New York

The Nepera exhibit features a new drug, *Choledyl,* which has been highly effective in the treatment of bronchial asthma, broncho-spasm and congestive heart failure. Choledyl assures high oral theophylline blood levels, with minimal side reactions; it rarely produces fastness.

Also featured:

Biomydrin Nasal Spray, for effective mucolytic-penetrating, antibacterial activity, prolonged nasal decongestion and antiallergic effect.

Biomydrin-F, adds Hydrocortisone Alcohol to the Biomydrin Nasal Solution formula. Biomydrin-F is anti-inflammatory, anti-allergic, mucolytic-penetrating, anti-bacterial and decongestant.

Urosulfin, a new product, which is a combination of a well-known soluble sulfonamide for anti-bacterial effect and a widely-used azo dye for rapid symptomatic relief of pain, burning, frequency, et cetera, in the treatment of urinary infections.

Wm. R. Niedelson Company **Booth No. 213**
Detroit, Michigan

We are introducing the PROFEXRAY ROCKET No. 100—the newest advance in office radiography. The JONES AIR-BASAL—the metabolism tester that eliminates oxygen tanks—: will be demonstrated, as well as the CARDIOTRON, a completely new model direct-writing Cardiograph with rectilinear response. Your visit will be welcome.

Noble-Blackmer, Inc. **Booth Nos. 118, 119**
Jackson, Michigan

Stop at Booth Nos. 118 and 119 and visit your friendly representatives from Noble-Blackmer, Inc. If you have time they will be glad to tell you about the latest developments in supplies and equipment.

Ortho Pharmaceutical Corporation **Booth No. P-21**
Raritan, New Jersey

ORTHO cordially invites you to visit their exhibit

at booth P-21. The Ortho display will feature PRECEPTIN® vaginal gel, their product for conception control, designed for use without a vaginal diaphragm. Preceptin vaginal gel has achieved an outstanding record of clinical effectiveness and has been widely acclaimed by the medical profession. Your inquiries on Preceptin vaginal gel are invited.

Parke, Davis & Company **Booth No. 209**
Detroit, Michigan

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products. Important specialties, such as Penicillin S-R, Benadryl, Ambodryl, Dilantin Suspension, Vitamins, Oxycel, Milontin, Amphedase, Chloromycetin, Thrombin Topical, et cetera, will be featured. You are cordially invited to visit our exhibit.

Pelton & Crane Company **Booth No. 306**
Detroit, Michigan

High speed autoclaves for the private office and small clinic are being demonstrated all during the meeting. One filling with water lasts all day. Sterilizing loads may be removed every thirteen minutes.
These self-contained units require an electric outlet only. Pelton autoclaves are the only office autoclaves which double as dry heat sterilizers also.

Pet Milk Company **Booth Nos. 201, 202**
St. Louis, Missouri

We will be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and INSTANT "Pet" Nonfat Dry Milk for special diets. A miniature "Pet" Evaporated Milk can will be given to all visitors.

Pfizer Laboratories **Booth No. 302**
Brooklyn, New York

The Pfizer exhibit again will be in the spotlight with its new and original concept of anti-stress, anti-infective therapy—TERRAMYCIN-SF and TETRACYN-SF. Also featured will be the complete line of Pfizer broad-spectrum antibiotics and STERAJECT as well as the new specialties, BONAMINE TABLETS, BONAMINE CHEWING TABLETS, TYZINE, and TOCLASE.

Picker X-Ray Corporation **Booth No. 603**
White Plains, New York

'Dial-the-part' automation distinguishes the new Picker Anatomatic Century II x-ray unit. Simple to use, it eliminates the need for technic charts or manual setting of separate technic factors. The operator merely "dials" the body part, makes a simple thickness-of-part setting, and pushes a button for the exposure. Coupled with this control is a new full size motor-driven table with a single x-ray tube quickly changed over from fluoroscopy to radiography.

Procter & Gamble Company **Booth No. 410**
Cincinnati, Ohio

Ivory soap (Procter & Gamble) offers a series of time-saving leaflet pads for doctors, each pad containing fifty identical tear-out sheets. These sheets, which may be given to patients, contain routine instructions covering six different topics. There are also samples of other free, helpful material prepared especially for physicians.
Mrs. Christyne Schwab in charge.

Professional Management **Booth No. 413**
Battle Creek, Michigan

PM

Business Counsel to the Medical Profession
Our account executives devote their full time to professional management. They are the *best informed men in the country* on the business side of your practice. Stop at Booth No. 413 and learn why PM clients enjoy a higher than average income at a lower cost to the patient.

Purdue Frederick Company **Booth No. 615**
New York, New York

Purdue Frederick Company will feature SENOKOT, new non-bulk, non-irritating constipation corrective acting selectively on the parasympathetic (Auerbach's) plexus in the large bowel, physiologically stimulating the neuromuscular defecatory reflex.
PRE-MENS, the multidimensional premenstrual tension therapy; COLPOTAB, a tested effective Tyrothricin trichomonacide; and CHLOROGIENE Duchettes, a hygienic douche formulation, will also be presented.

Randolph Surgical Supply Company **Booth Nos. 217, 219**
Detroit, Michigan

Reed & Carnrick **Booth No. 515**
Jersey City, New Jersey

Reed & Carnrick—invites you to demonstrations of —DIA-DISCS, for determining degree of sensitivity of bacteria to various antibiotics for therapeutic guidance—NEOBACIN Tablets for synergism of bacitracin and neomycin for preoperative sterilization of the bowel or treatment of diarrheas or dysenteries, and GINEBATIN SUPPOSITORIES for preoperative or therapeutic vaginal use.

R. J. Reynolds Tobacco Company **Booth No. 501**
Winston-Salem, North Carolina

Welcome to the R. J. Reynolds Tobacco Company Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMEL, CAVALIER King Size, or WINSTON, the distinctive new king size filter cigarette.

Riker Laboratories, Inc. **Booth No. 312**
Los Angeles, California

Riker Laboratories presents "PENTOXYLON," a new and more complete therapy in angina pectoris. "PENTOXYLON" combines the actions of "RAUWILOID," the alseroxylon fraction of Rauwolfia serpentina and of pentaerythritol tetranitrate (PETN). A truly important step toward providing a solution to the total clinical problem of angina pectoris. Visit Booth 312 for complete information.

A. H. Robins Company, Inc. **Booth No. P-20**
Richmond, Virginia

Physicians attending the Michigan State Medical Society meeting are extended a cordial invitation to visit the exhibit of the products of the A. H. Robins Company. Experienced medical representatives will be in attendance to welcome you and answer inquiries relative to any of Robins' prescription specialties.

J. B. Roerig and Company
Chicago, Illinois **Booth No. P-13**

J. B. ROERIG AND COMPANY's Booth No. P-13 will highlight ROETINIC, the new one a day capsule hematinic for all anemias amenable to oral therapy. Also featured will be BONADOXIN for the prevention of nausea and vomiting of pregnancy and postoperatively. ASF, Roerig's new anti-stress formula, VI THYRO, for the vitalized thyroid and improved

thyroid action and NEOBON, Roerig's new geriatric formulation. VITERRA, VITERRA THERAPEUTIC, AMPLUS, OBRON, OBRON HEMATINIC and HEPTUNA PLUS will also be available on request.

Sandoz Pharmaceuticals **Booth No. 301**
Hanover, New Jersey

FIORINAL A new approach to therapy of tension headaches and other head pain due to sinusitis and myalgiz.
BELLERGAL Time-tested and clinically proven as a potent autonomic inhibitor in a variety of psychosomatic disorders. Supporting clinical evidence will be presented.
CAFERGOT Available in oral and rectal form for effective control of head pain in migraine and other vascular headaches.
PLEXONAL A new hypnotic-autonomic and central acting drug potentiates the action of subthreshold doses of classic sedative agents.
BELLADENAL Anti-spasmodic sedative for the control of hypermotility with pain and hypersecretion of the intestinal tract.

W. B. Saunders Company **Booth No. P-2**
Philadelphia, Pennsylvania

Harold Rozema will be showing amongst the newest of our line: Cecil & Loeb: MEDICINE; Williamson: OFFICE PROCEDURES; Modell: RELIEF OF SYMPTOMS; Henry Ford Hospital: CARDIOVASCULAR SURGERY; Boyd: SURGICAL PATHOLOGY; Harvey & Bordley: DIFFERENTIAL DIAGNOSIS, and Cantarow & Trumper: CLINICAL BIOCHEMISTRY. These will be permanently displayed along with all our standard titles.

Schering Corporation **Booth No. P-8**
Bloomfield, New Jersey

Members of the Michigan State Medical Society and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured.
Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

Julius Schmid, Inc. **Booth No. 308**
New York, New York

An interesting and informative exhibit featuring RAMSES Flexible Cushioned Diaphragm; RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid, two new products embodying "Carlendacide," the recent development of Carl Henry Davis, M.D., and C. G. Grand for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES and SHEIK Rubber Condoms for the control of trichomonal reinfection.

G. D. Searle & Company **Booth No. P-23**
Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research. Featured will be Mictine, the new safe, non-mercurial oral diuretic; Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine and Pro-Banthine, the standards in anticholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

Sharp & Dohme, Inc. **Booth Nos. 216, 218**
Philadelphia, Pennsylvania

The Sharp & Dohme exhibit presents highlights on steroid therapy featuring "Deltra," "Hydrocortone," "Alflorone," and related steroids in respiratory allergies, endocrine disorders, eye diseases, collagen diseases, and skin conditions. Expertly trained personnel will be pleased to discuss new dosage forms, new indications, new management techniques, and the latest summaries of advanced clinical reports. A new anesthetic agent "Cyclaine" Hydrochloride with qualities suitable for such forms of regional anesthesia as infiltration, nerve block, spinal, caudal, and topical is of interest. Research data relative to more effective therapy when penicillin is used in conjunction with "Benemid" completes the exhibit.

Smith, Kline & French Laboratories **Booth No. P-5**
Philadelphia, Pennsylvania

The S.K.F. booth will feature the latest clinical information about the remarkable new drug—THORAZINE*—and its many and varied uses. These uses include potent anti-emetic action, potentiation of other drugs, and its unique and dramatic applications in the field of mental and emotional problems.
*"THORAZINE"—Trademark, S.K.F.

E. R. Squibb & Sons **Booth No. 418**
New York, New York

E. R. Squibb & Sons has long been a leader in development of new agents used in prevention and treatment of disease. The results of diligent research is quickly made available to the Medical Profession as new products or improvement on products already marketed.
At booth No. 418 we are pleased to present up-to-date information on these advances for your consideration.

The Stuart Company **Booth No. 105**
Chicago, Illinois

Representatives of the Stuart Company are featuring two new products. One is Suladyne, a more complete product for the treatment of urinary tract infections, and the other is Mulvidren, an entirely different type of multivitamin tablet for children 2 to 10.

Swift & Company **Booth No. 113**
Chicago, Illinois

THE ORIGINAL all-meat baby foods, Swift's Meats for Babies and Juniors, will be featured at the Swift exhibit. Literature and information on clinical research available. Also available is information about *new* Swift's Strained Chicken for Babies. Its pleasant mild flavor will make a delicious, taste-tempting change for any baby's diet.

Tampax Incorporated **Booth No. 617**
New York, New York

Your opinion of internal menstrual protection is important to your women patients. Tampax Educational Consultants at the exhibit will explain the correct use of the three absorbencies—Junior, Regular and Super.
Also displayed are Dickinson charts of female anatomy, Tampax teaching model, booklets for adolescents, medical reprints and literature on menstruation and menopause.

Testagar & Company, Inc. **Booth No. 310**
Detroit, Michigan

TESTAGAR & CO., INC. will show three new timed disintegrating capsules. TIMED PYMADEX is a trisynergistic antihistamine in a timed disintegrating capsule composed of three proven antihistamines. Smaller than average doses of each are used thereby minimizing possible side reactions to the patient and still affording the patient a maximum of effect. TIMED PYMADEX CAPSULES, a day-time partner to Timed Pyma Capsules also contains 6 mg. of

Dextro-Amphetamine to overcome any possible soporific aftereffects of the antihistamines and give the patient a sense of well-being. One TIMED PYMADEX CAPSULE at breakfast and one TIMED PYMA CAPSULE before retiring affords the patient protection around the clock. TIMED BAR-TROPIN CAPSULES are an antispasmodic capsule using tried and proven Atropine. One capsule at breakfast affords 10- to 12-hour (all-day) antispasmodic activity. Samples and literature will be available.

S. J. Tutag & Company **Booth No. 106**
Detroit, Michigan

S. J. Tutag & Company will feature Buffonamide brand of acet-dia-mer sulfonamide suspension at booth No. 106.

This outstanding cherry-flavored triple sulfa is unsurpassed among sulfa drugs for wide spectrum—high blood levels, palatability and minimal side effects. The non-settling, synergistic suspension contains Sodium Citrate for protection against crystalluria.

The Upjohn Company **Booth No. 203**
Kalamazoo, Michigan

Members of the medical profession are invited to visit the Upjohn booth where members of The Upjohn Company professional detail staff are prepared to discuss subjects of mutual interest.

U. S. Vitamin Corporation **Booth No. 107**
New York, New York

Exhibit features VI-AQUAMIN THERAPEUTIC . . . for the first time *aqueous* therapeutic vitamin formula with minerals in a *single capsule* to hasten recovery in medical, surgical and convalescent patients.

Professional samples and literature on Vi-Aquamin Therapeutic and other of our nutritional specialties will be distributed at the booth.

Warner-Chilcott Laboratories **Booth No. 419**
New York, New York

Two important cardiovascular agents will be featured at the Warner-Chilcott booth: Methium with Reserpine, a hypotensive-sedative, to lower blood pressure and relieve hypertensive symptoms and Peritrate to prevent attacks in angina pectoris. Parsidol, for the control of symptoms in parkinsonism, will also be exhibited. Representatives and research personnel will welcome an opportunity to discuss these drugs with you.

Westwood Pharmaceuticals **Booth No. 315**
Buffalo, New York

Westwood will display Gentia-Jel. The only effective gentian violet jelly you can prescribe for self treatment by the patient at home. Eliminates messy office treatments which often stain your furniture and clothing. Lowila Cake, the only completely soapless skin cleanser, in cake form, available to your allergic or dermatitic patients whenever soap is contraindicated. Obtain a Lowila Cake from the Westwood Booth for your own personal use.

White Laboratories **Booth No. 307**
Kenilworth, New Jersey

MOL-IRON—ferrous sulfate in a therapeutically potentiated form—has been described by competent investigators, as the most effective iron therapy known. Rapid hemoglobin increases plus a markedly low incidence of side-effects are two of the outstanding characteristics of the product. Mol-Iron is available in drop, liquid, and tablet forms, also as Mol-Iron with Calcium and Vitamin D, Mol-Iron with Liver and Vitamins and Mol-Iron E.M.F. (erythrocyte maturing factors).

Winthrop-Stearns, Inc. **Booth No. 406**
New York, New York

THEOMINAL R.S. (Theominal with Rauwolfia serpentina), an alliance of the classic and contemporary in antihypertensive compounds. Theominal R.S. combines the vasodilator and myocardial stimulant actions of theobromine and Luminal with the moderate central hypotensive effect of Rauwolfia serpentina. Gentle sedation calms the patient and a feeling of "relaxed well-being" is established. Headache and vertigo disappear as the blood pressure and pulse rate are reduced gradually.

Woodward Medical Personnel Bureau **Booth No. 607**
Chicago, Illinois

To those doctors seeking to re-locate, or to physicians who wish to reorganize or augment their present staff, Ann Woodward offers the facilities of the Woodward Medical Personnel Bureau. The details of excellent opportunities for above-average income, with good security and fine future potential may be investigated. You may also review the records of some exceptionally well-qualified younger doctors just finishing their formal training as well as diplomates of the specialties qualified to head departments. The complete files for these purposes may be found at Booth 607 where Mrs. Woodward will be available to greet and assist you.

Wyeth Laboratories **Booth No. 611**
Philadelphia, Pennsylvania

The Wyeth Laboratories exhibit will feature EQUANIL, a new anti-anxiety agent with muscle-relaxing properties. EQUANIL inhibits internuncial circuits in the subcortex without affecting the autonomic system, peripheral nerves, or the myoneural junction. Significant side-effects, toxic manifestations, or withdrawal phenomena have not been observed in widespread clinical trials.

Yakes Office Supply Company **Booth No. 516**
Grand Rapids, Michigan

Zimmer Manufacturing Company **Booth No. 402**
Warsaw, Indiana

Mr. C. A. Fisher, your Zimmer Distributor, extends a most cordial invitation to the members of the Michigan State Medical Society to visit his exhibit at Booth 402.

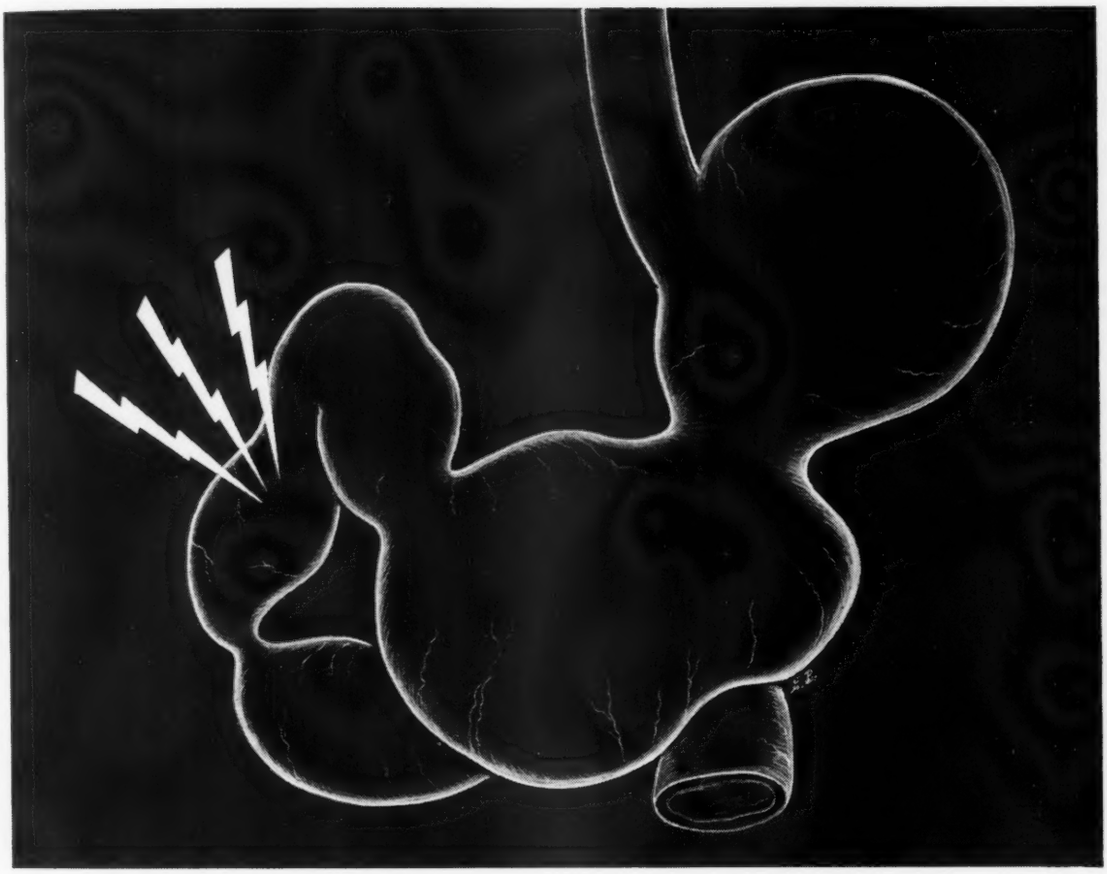
A complete line of Orthopedic Instruments and Fracture Equipment will be on display. Items of special interest, Badgley Nail, TITANIUM omplants, ZIMALOY new inert metal, Townley Cup Stem Prosthesis, Linbach Contour Medullary Screw, Schneider Self-Broaching Intramedullary Pins, "Underwriters Approved" Explosion Proof Luck Bone Saw and Brown-Electro Dermatome, DUROCEL a new "non-toxic" plastic foam padding which can be autoclaved and eliminates the use of stockinette—sheet wadding—felt or foam rubber.

ZIMMER, your guarantee of quality and prompt service.

THANKS

To our Business Friends in the Exhibit.

The Michigan State Medical Society expresses sincere thanks to the Technical Exhibitors for their splendid cooperation and very tangible contribution to the great success of the 1955 MSMS Annual Session.



Abnormal Motility as the Cause of Ulcer Pain

Until recently the general opinion was held that ulcer pain was primarily caused by the presence of hydrochloric acid on the surface of the ulcer.

Present investigations[1,2] on the relationship of acidity and muscular activity to ulcer pain have led to the following concept of its etiologic factor:

"... abnormal motility[2] is the fundamental mechanism through which ulcer pain is produced. For the production and perception of ulcer pain there must be, one, a stimulus, HCl or others less well understood; two, an intact motor nerve supply to the stomach and duodenum; three, altered gastro-duodenal motility; and four, an intact sensory pathway to the cerebral cortex."

Pro-Banthine® has been demonstrated consistently to reduce hypermotility of the stomach and intestinal tract and in most instances also to reduce gastric acidity. Dramatic remissions[1] in peptic ulcer have followed Pro-Banthine therapy. These remissions (or possible cures) were established not only on the basis of the disappearance of pain and increased subjective well-being but also on roentgenologic evidence.

Pro-Banthine Bromide (Beta-diisopropylaminoethyl xanthene-9-carboxylate methobromide, brand of propantheline bromide) has other fields of usefulness, particularly in those in which vagotonia or parasympathotonia is present. These conditions include hypermotility of the large and small bowel, certain forms of pylorospasm, pancreatitis and ureteral and bladder spasm.

1. Schwartz, I. R.; Lehman, E.; Ostrove, R., and Seibel, J. M.: A Clinical Evaluation of a New Anticholinergic Drug, Pro-Banthine, Gastroenterology *25*:416 (Nov.) 1953.

2. Ruffin, J. M.; Baylin, G. J.; Legerton, C. W., Jr., and Texter, E. C., Jr.: Mechanism of Pain in Peptic Ulcer, Gastroenterology *23*:252 (Feb.) 1953.

SEARLE

Michigan's Department of Health

Albert E. Heustis, M.D., Commissioner

DISTRIBUTION AND USE OF POLIO VACCINE IN MICHIGAN

The Governor's Advisory Committee on Distribution of Poliomyelitis Vaccine approved, with slight modifications, the recommendations of the Commissioner's Special Technical Committee on Immunization in regard to distribution and use of the vaccine in Michigan. The recommendations were then adopted by the State Health Commissioner.

In general, the Committee feels that the total preventive effect of the vaccine in a period of rising poliomyelitis incidence should be much greater than any possible hazard from the provoking effects of the injection.

The Committee feels, also, that for the present all poliomyelitis vaccine available to Michigan should come directly to the Michigan Department of Health to be allotted to counties on a formula basis. The amount sent to each area will depend upon the relative proportion of priority children in the county—figured in strict ratio to the number of priority children in the state as a whole.

Local distribution will be governed by local arrangements.

As to the so-called provoking effect of Salk vaccine when used extensively during epidemic periods, this must be considered in an entirely different light from the possible provoking effect of injectable materials which do not produce an immune response against poliomyelitis infection.

Poliomyelitis vaccine has been shown to reduce incidence of paralytic poliomyelitis by 80 to 90 per cent. This reduction is particularly striking in severe and fatal forms of the disease.

The vaccine is expected to produce some antibody response as early as a week to ten days following the first shot. Even small amounts of antibodies are believed to have some effect in preventing paralytic polio after this interval. Therefore, the onset of an antibody response to the vaccine may well eliminate any subsequent provoking effect of the vaccine injection.

Experience with the polio vaccine in 1954 and 1955 showed no evidence of any significant provoking effect of the vaccine.

Even the small potential risk of the provoking effect of injections probably can be reduced still further by avoiding any such injections in persons with symptoms of minor illness, especially fever, sore throat or gastrointestinal upsets, and for a period of at least two weeks thereafter.

The vaccine should not be given to persons in a household where a case of poliomyelitis has just occurred, since almost all of the other members of the household are already infected when the case is identified. There is greater possibility that injections might provoke paralysis.

As to the localizing effect of the vaccine, evidence indicates that the risk of localizing the paralysis or of provoking a paralytic attack of poliomyelitis by giving the vaccine is small. The duration of such a possible effect is limited to about three weeks following an injection.

There is only scanty evidence that injections other than poliomyelitis immunizations increase the risk of acquiring paralytic poliomyelitis in injected individuals during epidemic periods. However, the effect of localization of a developing paralysis to the injected extremity has been clearly shown. Therefore, it is still considered advisable that booster injections against common infectious diseases, such as diphtheria, whooping cough and tetanus be postponed during the periods of high poliomyelitis incidence.

This does not contradict the recommendation that Salk vaccine should be given during periods of high poliomyelitis incidence. The Salk vaccine is specific for poliomyelitis.

In both recommendations, the same rule is followed: Injection is given only when the risk of the disease to be prevented by the injection is greater than the presumed risk of converting an asymptomatic poliomyelitis infection into a paralytic one—or of localizing the paralysis to the injected extremity.

As to the limitations of the Salk vaccine, when it is given to large numbers of persons during periods of rising incidence, a small proportion may be in the incubation period and may subsequently experience paralytic disease. Persons receiving the poliomyelitis vaccine during the early, silent period of a poliomyelitis infection may not be protected. And they may be subject to a localizing effect of paralysis at the site of the injection.

Experience so far this year has shown, too, that a number of cases may be erroneously reported as poliomyelitis which are other diseases with clinical similarities.

And, of course, the vaccine is not 100 per cent effective.

It is considered extremely significant that in 26,000 Michigan youngsters who received the placebo substance in the field trials last year, there were thirty-seven cases of paralytic poliomyelitis. In the same number of youngsters who received the poliomyelitis vaccine, there were only three cases of paralytic poliomyelitis.

The Committee concluded that benefit to be gained by poliomyelitis immunization, in contrast to the small potential risk of provocation, increases in proportion to the severity of the poliomyelitis incidence—since a larger number of paralytic cases should be prevented during the entire period of any epidemic.

. . . . . NEWS MEDICAL

MICHIGAN STATE MEDICAL SOCIETY ANNUAL SESSION

Civic Auditorium—Pantlind Hotel, Grand Rapids
Wednesday-Thursday-Friday, September 28, 29, 30, 1955
YOU are invited to attend the Ninetieth

MICHIGAN AUTHORS

Waldemar E. Gizynski, M.D., Detroit, is the author of an article entitled "Program Highlights Central Association of Obstetricians and Gynecologists," published in the *Harper Hospital Bulletin,* March-April, 1955.

Thomas Francis, Jr., M.D., Ann Arbor, is the author of an article entitled "Approach to Control of Poliomyelitis by Immunological Methods" published in the *Bulletin of the New York Academy of Medicine,* April, 1955.

William G. McDevitt, M.D., F.A.C.S., F.I.C.S., Detroit, is the author of an article entitled "A Method for Correction of Blepharoptosis," read at the Nineteenth Annual Congress of the United States and Canadian Sections, International College of Surgeons, Chicago, September, 1954, and published in *The Journal of the International College of Surgeons,* June, 1955.

K. T. Johnstone, M.D., Saginaw, is the author of an article entitled "The Identification of Accident Proneness" which was presented at the Seventeenth Annual General Motors Medical Conference, Buffalo, New York, April, 1955, and published in *Industrial Medicine and Surgery,* July, 1955.

William B. Taylor, M.D., and **Richard E. Dickes, M.D.**, Ann Arbor, are the authors of an article entitled "The Carcinogenic Properties of Cutting Oils," published in *Industrial Medicine and Surgery,* July, 1955.

Earl F. Lutz, M.D., Detroit, is the author of an article entitled "The Tetanus Problem" presented at the General Motors Medical Conference, Buffalo, New York, April, 1955, and published in *Industrial Medicine and Surgery,* July, 1955.

A. Burgess Vial, M.D., Ann Arbor, is the author of an article entitled "Succinylcholine and Artificial Respiration in the Treatment of Tetanus: Report of a Case," published in *University of Michigan Medical Bulletin,* May, 1955.

Robert M. Reynolds, A.B., M.D., Ann Arbor, is the author of an article entitled "Adrenal Hemorrhage in Adults: Two Case Reports," published in the *University of Michigan Medical Bulletin,* May, 1955.

P. E. Hodgson, M.D., D. A. Moosman, M.D., and **M. R. Abell, M.D.**, Ann Arbor, are the authors of an article entitled "Surgery Staff Conference: Diseases of the Gallbladder," published in the *University of Michigan Medical Bulletin,* May, 1955.

William C. Baum, M.D., Ann Arbor, is the author of an article entitled "Oxytetracycline in the Treatment of Infections of the Genitourinary Tract" published in the *International Record of Medicine and General Practice Clinics,* April, 1955.

Allen I. Bortz, M.D., and **Frank H. Bethell, M.D.**, Ann Arbor, are the authors of an article entitled "Pigmented Spots of the Oral Mucosa, Lips and Digits Associated with Gastrointestinal Polyposis," published in the *Digest of Ophthalmology and Otolaryngology,* April, 1955.

Prescott Jordan, Jr., M.D., and **Harper K. Hellems, M.D.**, Detroit, are the authors of an article entitled "Surgical Treatment of Aortic Insufficiency," published in the *Harper Hospital Bulletin,* March-April, 1955.

Paul De Kruif, Ph.D., Holland, is the author of an article entitled "News for the Itching," published in *Today's Health,* July, 1955.

Thomas Geoghegan, M.D., and **Brock E. Brush, M.D.**, Detroit, are the authors of an article entitled "Relationship of Corticotropin (ACTH) to the Healing of Gastrointestinal Anastomoses," published in AMA *Archives of Surgery,* June, 1955.

J. Reimer Wolter, M.D., Ann Arbor, is the author of an article entitled "The Cells of Remak and the Astroglia of the Normal Human Retina," published in AMA *Archives of Ophthalmology,* June, 1955.

James E. Coyle, M.D., and **Samuel L. Balofsky, M.D.**, by invitation, Detroit, are the authors of an article entitled "Current Trends in Radiotherapy of Head and Neck Cancer," published in *Transactions of the American Academy of Ophthalmology and Otolaryngology,* March-April, 1955.

Richard C. Woellner, Chicago, by invitation, and **Harold F. Schuknecht, M.D.**, Detroit, are the authors of an article entitled "Hearing Loss from Lesions of the Cochlear Nerve: An Experimental and Clinical Study," published in *Transactions of the American Academy of Ophthalmology and Otolaryngology,* March-April, 1955.

(Continued on Page 1004)

(Continued from Page 1002)

Merle Lawrence, Ph.D., Ann Arbor, by invitation, is the author of an article entitled "In Vitro Studies of Bone from the Developed Human Otic Capsule," published in *Transactions of the American Academy of Ophthalmology and Otolaryngology,* March-April, 1955.

Elisha S. Gurdjian, M.D., John E. Webster, M.D., Frederick R. Latimer, M.D., Sander P. Klein, M.D., and **James E. Lofstrom, M.D.,** Detroit, are the authors of an article entitled "Recent Advances in Surgical Management of Chromophobe Tumor of Pituitary," published in *The Journal of the American Medical Association,* May 7, 1955.

Basil I. Hirschowitz, M.D., M.R.C.P., David H. P. Streeten, Dr. Phil., M.R.C.P., M. Marvin Pollard, M.D., and **Henry A. Boldt, Jr., M.D,** Ann Arbor, are the authors of an article entitled "Role of Gastric Secretions in Activation of Peptic Ulcers by Corticotropin (ACTH)," published in *The Journal of the American Medical Association,* May 7, 1955.

Brock E. Brush, M.D., and **Thomas J. Heldt, M.D.,** Detroit, are the authors of an article entitled "A Device for Relief of Lymphedema," published in *The Journal of the American Medical Association,* May 7, 1955.

Leo S. Figiel, M.D., and **Steven J. Figiel, M.D.,** Detroit, are the authors of an article entitled "Volvulus of the Transverse Colon" published in *Radiology,* a condensation of which appears in the *American Practitioner and Digest of Treatment,* June, 1955.

P. J. Melnick, M.D., Eloise, is the author of an article entitled "Polycystic Liver," published in *American Journal of Pathology,* a condensation of which appears in *American Practitioner and Digest of Treatment,* June, 1955.

Rudolf E. Wilhelm, M.D., Dearborn, Michigan; **Helen M. Nutting, A.B.; H. B. Devlin, Ph.D.; Elmer R. Jennings, M.D.,** and **Osborne A. Brines, M.D.,** Detroit, are the authors of an article entitled "Antihistaminics for Allergic and Pyrogenic Transfusion Reactions," published in *The Journal of the American Medical Association,* June 18, 1955.

Paul V. Woolley, Jr., M.D., and **William A. Evans, Jr., M.D.,** Detroit, are the authors of an article entitled "Significance of Skeletal Lesions in Infants Resembling Those of Traumatic Origin," published in *The Journal of the American Medical Association,* June 18, 1955.

James L. Wilson, M.D., and **David G. Dickinson, M.D.,** Ann Arbor, are the authors of an article entitled "Prevention of Long-Time Dependence of Poliomyelitis Patients on Tank Respirator," published in *The Journal of the American Medical Association,* June 18, 1955.

Joseph H. Chandler, M.D., Ann Arbor, is the author of an article entitled "Reserpine in the Treatment of Huntington's Chorea," published in the *University of Michigan Medical Bulletin,* April, 1955.

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C. William Castor, M.D., and **William H. Beierwaltes, M.D.,** with the technical assistance of **Emily Dorstewitz** and **Joanne E. Auch,** Ann Arbor, are the authors of an article entitled "The Effect of Dinitrophenol on Protein-Bound Iodine in Man: A Preliminary Report," published in the *University of Michigan Medical Bulletin,* April, 1955.

Robert E. McClellan, M.D., Ann Arbor, is the author of an article entitled "Unusual Case Report: Buckshot Colic," published in the *University of Michigan Medical Bulletin,* April, 1955.

* * *

The American Society of Human Genetics will hold its annual meeting in conjunction with the AIBS meeting in East Lansing, September 6 through September 8, 1955. Physicians in that area with an interest in hereditary aspects of disease may be interested in attending some of these sessions.

* * *

Represented at Geneva.—Some 100 U. S. industrial and commercial firms, along with fifty academic, professional and private educational and research organizations, will be represented in exhibits at the International "atoms-for-peace" conference at Geneva, Aug. 8-20. Several commercial concerns will have displays in more than one of the exhibits. Michigan organizations to be represented are Detroit Edison Company, Detroit; Michigan State University, East Lansing; Radioactive Products, Inc., Detroit; University of Michigan, Ann Arbor; and Bendix Aviation Corporation, Detroit.

* * *

New Group Formed.—At the recent meeting of the Upper Peninsula Medical Society, a new group was formed consisting of the radiologists of the Upper Peninsula of Michigan. The group will be known as the Upper Peninsula Radiological Society. The following officers were elected: Dr. L. Grant Glickman, Menominee, president; Dr. T. Boyd Bolitho, Marquette, vice-president, and Dr. Arthur Gonty, Menominee, secretary. The group will meet quarterly.

* * *

Noah E. Aronstam, M.D., Detroit, addressed the Detroit Philosophical Society on the subject "Glances in the Anthropology of Medicine" on June 24, 1955, at the Wayne University Science Building. The speaker was honored at a dinner preceding the meeting.

* * *

Rheumatic Fever TV Program.—A panel discussion on rheumatic fever and part of "The Valiant Heart" was presented from WNEM-TV on May 15, 1955. It was hoped that this whole program would be tape recorded in order to prepare an article for THE JOURNAL of the Michigan State Medical Society from the material presented, but unfortunately this was not done.

This program was organized by Robert E. Fisher,

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M.D., of Bay City, and the following physicians of the adjacent counties took part: C. F. Wible, M.D., Sebewaing; W. L. Howland, M.D., Pinconning; H. T. Knobloch, M.D., Bay City; Bert Bullington, M.D., Saginaw; Harold T. Donahue, M.D., Cass City; M. S. Chambers, M.D., Flint; L. O. Shantz, M.D., Flint; B. O. O'Hora, M.D., Midland; L. R. Wickert, M.D., Mt. Pleasant; T. Finkelstein, M.D., Flint; Frank Johnson, M.D., Flint; J. E. Harroun, M.D., Owosso; R. M. Jarvi, M.D., Saginaw; Raymond J. Winfield, M.D., Marlette; Glenn Smith, M.D., Imlay City; Scott Harris, M.D., Ypsilanti; L. Fernald Foster, M.D., Bay City; R. E. Fisher, M.D., Bay City; and Mrs. William Dibble, 3160 Skander Drive, Flint.

* * *

The American Medical Association has published a 24-page pamphlet on "Community Efforts Provide Medical Facilities." It tells the story of how various communities made efforts to secure doctors. This is a report from the Committee on Medical and Related Facilities, with Ralph A. Johnson, M.D., Detroit, as chairman.

A complete story along with the sketches of eight doctors' offices, is provided, two of which were in Michigan, one at Hillman and one at Onaway. Short comments with pictures of clinic buildings at four other places are also given. It is interesting that in this group, two of Michigan's efforts are completely described.

* * *

J. P. Gray, B.A., M.D., M.P.H., Detroit, will speak at the American Medical Writers' Association Twelfth Annual Meeting to be held in St. Louis in September, 1955. The subject of his talk will be "Report on A.M.W.A. Visiting Lectureship to the Medical Colleges."

* * *

Brock E. Brush, M.D., W. L. Lowrie, M.D., and **W. E. Redfern, M.D.,** Detroit, will be scientific exhibitors at the Twentieth Annual Meeting of the Mississippi Valley Medical Society to be held in St. Louis in September, 1955.

* * *

John W. Smillie, M.D., Ann Arbor, presented a paper on "Cataract Surgery in Megalocornea" before the Section on Ophthalmology, at the 104th Annual Meeting of the American Medical Association, Atlantic City, June 9, 1955.

* * *

George Curry, M.D., Flint, will participate in a panel on Trauma which will be a part of the program of the Interstate Postgraduate Medical Association to be held in Milwaukee, Wisconsin, November 14-17, 1955.

* * *

"Endocrinology and Metabolism" is the subject for the seventh annual Postgraduate Assembly of the Endocrine Society, being held in Indianapolis, September 26-October 1, with the co-operation of the Indiana University School of Medicine.

Continuation study facilities of the Indiana University Medical Center will be utilized for the sessions at

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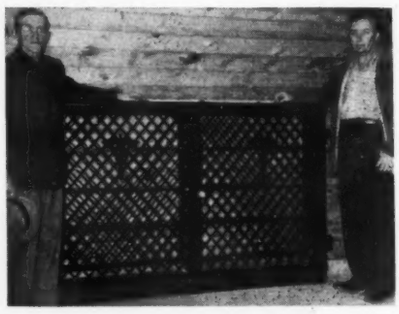
which twenty-one leading clinicians and investigators will be heard.

Information regarding the program, registration, et cetera, is available by addressing: Postgraduate Office, Indiana University School of Medicine, 1100 West Michigan St., Indianapolis 7, Indiana.

* * *

Wm. S. Jones, M.D., President-Elect of the Michigan State Medical Society, and for years a member of the Beaumont Restoration Committee, and Mrs. Jones have given the Michigan State Medical Society for the Beaumont Memorial, a priceless gift—a set of books of the Beaumont age.



The books are housed in the memorial and to protect them a set of grilles has been made by a blacksmith artist at the Stadula Blacksmith Shop in Daggett. They are steel riveted with small copper rivets, as shown in the accompanying illustration. Again, we thank Dr. and Mrs. Jones for their generosity.

* * *

The Sixth Annual Clinic on Trauma, sponsored by the Central Michigan Committee, Michigan Regional Committee on Trauma of the American College of Surgeons, and the Medical Society of North Central Counties, was held at Hidden Valley, Gaylord, on July 28. This meeting and future clinics are to be known as the "Doctor Claude R. Keyport Trauma Day," recognizing the pioneer work done by the late Doctor Keyport, MSMS Past President.

* * *

The Ohio Academy of General Practice will hold its Fifth Annual Scientific Assembly at the Dayton Biltmore Hotel, Dayton, Ohio, September 20-21. For program, write Earl D. McCallister, M.D., 209 S. High St., Columbus 15, Ohio.

* * *

Willard B. Howes, M.D., and **William P. Chester, M.D.,** both of Detroit, were re-elected as Regent for Michigan-Ohio and as Governor for Michigan, respectively, of the American College of Chest Physicians, at its recent Atlantic City meeting.

* * *

The Association of Military Surgeons of the United States will hold its 62nd Annual Convention at the Statler Hotel, Washington, D. C., November 7-8-9, 1955. For complete information and program, write the Association at Suite 718, New Medical Building, 1726 Eye Street, N.W., Washington 6, D. C.

Louis J. Hirschman, M.D., Traverse City, was honored at Wayne University's 87th annual alumni reunion in Detroit when he was presented with the University's Alumni Award. Dr. Hirschman was graduated from Wayne University College of Medicine in 1899.

The author of several textbooks in his professional field of proctology and of chapters in the Yearbook of Anesthesia, Dr. Hirschman is currently Associate Editor of the *American Journal of Surgery* and of the *American Journal of Digestive Diseases.* He was a member of the Wayne Medical School faculty from 1904 until 1946; he has been President of the Wayne County Medical Society, of the Michigan State Medical Society, the American Proctological Society, Wayne University College of Medicine Alumni Association, Detroit Academy of Medicine, and the Detroit Medical Club (founder).

This is the second time Wayne University has honored Dr. Hirschman; in 1952, he was awarded the Distinguished Service Citation.

Dr. Hirschman also was honored by the American Proctological Society, at its 1955 meeting in New York City, when he was made a member of the APS Fifty-Year Club, signifying the completion of fifty years of practice of medicine.

* * *

Thomas A. Grekin, M.D., Eloise, was awarded first prize in the annual competition sponsored by the Trauma and Nutrition Committees of the American College of Surgeons. The competition papers were written by residents and interns from the State of Michigan and from Toledo, Ohio. Dr. Grekin's subject was "Peritoneal Aspiration." At the committee's recent meeting in Ann Arbor, 250 were registered. The F. A. Coller Award was presented to Dr. Grekin at the banquet.

* * *

William J. Burns, Executive Director of the Michigan State Medical Society, received a Twenty-Five Year Achievement Award at the Atlantic City meeting of the Medical Society Executives Conference, held coincident with the 1955 American Medical Association Annual Session.

* * *

The National Board of the American Cancer Society will hold its annual meeting at the Sheraton-Cadillac Hotel, Detroit, during the week of June 4, 1956.

* * *

Joseph T. Noe, M.D., has been appointed Medical Director of Wyandotte Chemicals Corporation, to fill the vacancy created by the death in March of William H. Honor, M.D.

* * *

Sidney J. Shipman, M.D., of San Francisco, a native of Michigan and graduate of the University of Michigan Medical School ('17, '19m), has been elected president of the California Medical Association. Dr. Shipman is a Past President of the National Tuberculosis Association and is now Professor of Medicine of the

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niversity of California Medical School. He is also st president of the San Francisco Medical Society.

* * *

The Wayne County Medical Society approved the cent report of its Public Relations Committee that the ociety accept the offer of the *Detroit Free Press* to onsor again a Public Health Forum to be held Sepmber 12-19-26 at the Rackham Building, Detroit. The bjects of the first two meetings will be (a) Heart iseases and (b) Arthritis and Rheumatism.

A different approach is planned for these forums. In lace of a didactic lecture with discussion on symptoms and treatments, it is planned to stress what the atient can do to adjust and alleviate his condition; or example, in discussing heart diseases, the panel will ttempt to show how the patient can revise his daily attern in order to live more completely with his handiap. It is planned to use visual aids, such as short ilms and to co-operate with interested organizations uch as the Michigan Heart Association, the Michigan Rheumatism Association, and others.

William Bromme, M.D., Detroit, was requested to ssume responsibility for the arrangements of the forums.

* * *

H. Marvin Pollard, M.D., Ann Arbor, was recently appointed Secretary-General of the First World Congress of Gastroenterology, at a meeting of the American Gastrological Association in Atlantic City. The World Meeting is slated to be held in the United States in 1958.

Dr. Pollard also was re-elected Secretary of the American Association.

Congratulations, Dr. Pollard!

* * *

Roger V. Walker, M.D., Detroit, was honored at a meeting in the Detroit Mayor's office on June 10. Mr. Cobo thanked Dr. Walker for eleven years of service as a member of the Board of Health.

* * *

Wolf W. Zuelzer, M.D., Detroit, was elected President of the Society for Pediatric Research at its annual meeting in Quebec, held in conjunction with members of the Canadian, British and American Pediatric Societies.

* * *

J. W. Rigterink, M.D., was featured in a "profile" sketch in *St. Mary's Hospital* (Grand Rapids) *Bulletin* of June, 1955. The eighty-three-year-old internist, whose career has spanned fifty-four years of practice, claims that the advice of a grade school teacher started him on his medical career. This teacher told young Rigterink and the other members of his class: "For true happiness in life, devote your life to others."

Congratulations, Dr. Rigterink, on a career of service to others!

R. A. C. Wollenberg, M.D., Detroit, was honored with a testimonial dinner, at the Detroit Athletic Club on June 29, in celebration of fifty years of medical practice and his fiftieth wedding anniversary. Exactly fifty friends gathered to honor the Detroit dermatologist, presenting him with a scroll with the following poem written thereon by one of the Sisters of Mt. Carmel Mercy Hospital, Detroit:

THE PHYSICIAN

Deftly he handles the scalpel,
Skillfully heals the ill,
Tenderly smoothes the fevered,
Forces the fears be still.

Selflessly spends of his powers,
Day and at night is on call,
Assisting the new-born and dying,
Assuring and comforting all.

Patiently treats the psychotic,
Rightens the life of the stray,
For Christ is at work in the doctor,
The light and the strength of his day.

* * *

A. E. Heustis, M.D., Michigan Health Commissioner, received an Honorary degree of Doctor of Laws from Michigan State College at the annual spring convocation.

The citation read:

"ALBERT E. HEUSTIS, physician, researcher, guardian of the public health. Through diligent effort, you prepared yourself to practice one of the highest arts known to man: that of safeguarding the health of human beings and of protecting them against the ravages of widespread disease. This training, and your experience as a director of county health programs, qualified you for your present important office of State Health Commissioner, in which you are serving in such a manner as to furnish an example of outstanding leadership and vision to the entire nation. Your distinguished professional achievements to date give promise of an even wider extension of the benefits of the public health program of the state of Michigan."

Congratulations, Dr. Heustis!

* * *

Michigan's Health, the monthly publication of the Michigan Department of Health, featured in its April, 1955, number, an article on cancer-phobia with the subheading of "See Your Doctor for Appraisal."

Two paragraphs of this interesting lead story read as follows:

"Dr. Albert E. Heustis, state health commissioner, says the first thing to do if you are worried about cancer is to "Make an appointment with your family physician.

"Cancer-phobia," he said, "which we can define as incessant fear of the disease, will only run down your health. By seeing your doctor for a periodic health appraisal, you can get the peace of mind that comes from his examination, and if cancer should be found, the rewards of early detection may be yours."

* * *

William M. LeFevre, M.D., of Muskegon, Councilor of the Eleventh District and an avocational woodcarver of high repute, has hand-turned a wooden caduceus which will be placed over the door of the MSMS hospitality booth, used during MSMS Annual Sessions in Grand Rapids. The caduceus is being gold leafed by Dr. LeFevre.

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The American Urological Association offers an annual award of $1,000 for three essays on the result of some clinical or laboratory research in urology. For full particulars, write Executive Secretary, W. P. Didusch, 1120 N. Charles Street, Baltimore, Maryland. Essays must be submitted before December 1, 1955.

* * *

S. A. Gaffney, long-time representative of Merck & Company, Rahway, New Jersey, and a good friend of hundreds of Michigan doctors of medicine whom he met at MSMS Annual Sessions, died after an illness of several months at his home in Lansdowne, Pennsylvania, June 19.

MSMS has lost a good friend and nation-wide "booster" in Si Gaffney.

* * *

New fields of atomic research were opened to University of Michigan scientists on June 9 with the dedication of the ultramodern Phoenix Memorial Laboratory, believed to be unequalled outside government facilities. The three-story, glass and brick structure, located on the new North Campus in Ann Arbor, is a living monument to the University of Michigan's dead of World War II.

The $1,500,000 structure will make possible studies involving the most powerful sources of atomic energy, and contains the latest facilities for handling and storing these materials. A $1,000,000 nuclear reactor is under construction at one end of the building and will be in operation next year. Both the laboratory and reactor were made possible by gifts to the University of Michigan Memorial-Phoenix Project, a program of study of the peaceful uses of atomic energy. The laboratory will conduct only peaceful atomic investigations with no security restrictions on the open research.

* * *

John W. Castellucci, Executive Director of Blue Shield Medical Care Plans, has announced that the recently-tried infringement suits in Texas and Mississippi, involving the well-known Blue Shield service mark and the shield symbol, have been settled. The validity of the Blue Shield service marks has been recognized. The defendants, who were using Blue Seal and White Seal, have each agreed to stop immediately any further preparation of sales material, or advertising of any kind, using these marks. Details of the settlement are set out in Agreements filed with the U. S. District Courts in Austin, Texas, and in Jackson, Mississippi, where the cases were tried.

* * *

British Can't Link Cancer to Cigarets—A series of tests in Britain have produced no link between cigaret smoke and lung cancer, the British Empire Cancer Society reported Tuesday at its annual meeting.

Five strains of mice were treated for eighteen months with two preparations from cigaret smoke tar. "Large groups" of other mice were exposed to cigaret smoke all their lives. Twenty-four hamsters were exposed to the smoke of fifty cigarets daily in a special cabinet for eight months.

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All the tests have been negative, the society announced, but in view of their importance, they are being expanded and continued.

Another series of tests has sought a possible link between soil and stomach cancer. Soil samples were taken from gardens of homes in Wales and England where people died from different forms of cancer.

"The preliminary results suggest there may be some association between cancer of the stomach and certain soil characteristics," the society announced.—*Detroit Free Press,* July 13, 1955.

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DOCTOR LOCATIONS--THROUGH JUNE 30, 1955

Name	Opened Practice in	Approximate Date
Placed by Michigan Health Council		
L. G. Agin, M.D.	Ann Arbor	June 1
H. Leighton Williams, M.D.	Hart	June 20
Roy A. Landry, M.D.	Waterford	June
Assisted by Michigan Health Council		
Gustave Prinsell, M.D.	Saginaw	June 19
Homer G. Slade, M.D.	Saginaw	June 19
Luther H. Zick, M.D.	Benton Harbor	June 1

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column, and this will be deemed by us as full compensation to those sending them. A selection will be made for review, as expedient.

AN EVALUATION OF THE POLIOMYELITIS VACCINE TRIALS. Summary Report by Thomas Francis, Jr., M.D., Robert F. Korns, M.D., Robert B. Voight, B.S., Morton Boisen, B.A., Fay M. Hemphill, Ph.D., John A. Napier, Eva Tolchinsky. From the Poliomyelitis Vaccine Evaluation Center, University of Michigan, Ann Arbor, Michigan, April 12, 1955. Sponsored by The National Foundation for Infantile Paralysis. Published in the American Journal of Public Health and the Nation's Health, May, 1955.

NEEDED RESEARCH IN HEALTH AND MEDICAL CARE. A Bio-social Approach by Cecil G. Sheps, M.D., M.P.H., and Eugene H. Taylor, M.D., M.P.H. Based on a Seminar held in Chapel Hill in September, 1952. Chapel Hill: The University of North Carolina Press, 1955. Price, $5.00.

THE MANUAL OF ANTIBIOTICS 1954-1955. Prepared under the editorial direction of Henry Welch, Ph.D. Price $2.50.

REVIEW OF MEDICAL MICROBIOLOGY by Ernest Jawetz, Ph.D., M.D., Professor of Bacteriology and Lecturer in Medicine and Pediatrics, University of California School of Medicine, San Francisco; Joseph L. Melnick, Ph.D., Professor of Epidemiology, Yale University School of Medicine, New Haven; Edward A. Adelberg, Ph.D., Assistant Professor of Bacteriology, University of California, Berkeley. Lange Medical Publications, P.O. Box 1215, Los Altos, California, 1954. Price $4.50.

ANNUAL REPORT OAKLAND COUNTY DEPARTMENT OF HEALTH, 1953.

THE CITY OF HOPE. Samuel H. Golter, G. P. Putnam's Sons, New York. Price $3.50.

SIMPLIFIED DIABETIC MANAGEMENT. By Joseph T. Beardwood, Jr., A.B., M.D., F.A.C.P., Professor of Diseases of Metabolism, Graduate School of Medicine, University of Pennsylvania; Director of Medical Services, Abington Memorial Hospital, Abington, Pa.; Chief of the Metabolic Department, Philadelphia General Hospital-Northern Division; Consultant to the Metabolic Service of the Presbyterian Hospital in Philadelphia and Herbert T. Kelly, M.D., F.A.C.P., Associate in Medicine, Graduate School of Medicine, University of Pennsylvania; Associate Physician, Presbyterian Hospital; Chief, Department of Medicine, Doctor's Hospital; Chairman of the Committee on Nutrition, Medical Society of the State of Pennsylvania; Honorary Chairman, Pennsylvania Nutrition Council. Sixth Edition. Philadelphia and Montreal: J. B. Lippincott Company. Price $3.00.

MANAGEMENT OF ADDICTIONS. Edited by Edward Podolsky, M.D., Department of Psychiatry, Kings County Hospital, Brooklyn, New York. Editor of "Music Therapy" and "War Medicine." New York: Philosophical Library, 1955. Price $7.50.

HANDBOOK OF PEDIATRICS. By Henry K. Silver, M.D., Associate Professor of Pediatrics, Yale University School of Medicine, New Haven, Connecticut; C. Henry Kempe, M.D., Assistant Professor of Pediatrics, University of California School of Medicine, San Francisco, California; Henry B. Bruyn, M.D., Assistant Professor of Pediatrics and Medicine, University of California School of Medicine,

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San Francisco, California, Assistant Clinical Professor of Pediatrics, Stanford University Medical School, San Francisco, California. Los Altos, California: Lange Medical Publications, 1955. Price, $3.00.

This book is entitled "Handbook" and was written to supplement more complete pediatric texts. However, when one carefully examines the Handbook of Pediatrics it becomes readily evident that this is perhaps one of the most complete ready references on pediatrics that has appeared in many years.

There are 537 pages containing all the pertinent information one could wish, well-written, concise and yet fairly complete with up-to-the-minute accepted ideas and therapy. The authors make good use of illustrations for various procedures and have many prepared tables to enable quick comparisons. The subjects covered are complete for the pediatrician and contain several from the clinical and practical point of view not found in standard texts. This is a worthwhile addition to any library.

PERINATAL MORTALITY IN NEW YORK CITY. Responsible Factors. A Study of 955 Deaths by the Subcommittee on Neonatal Mortality, Committee on Public Health Relations, the New York Academy of Medicine. Analyzed and reported by Schuyler G. Kohl, M.S., M.D., Dr.P.H. Published for The Commonwealth Fund. Cambridge: Harvard University Press, 1955. Price, $2.50.

This report emphasizes continuing need for expert obstetrical and pediatric care if the perinatal mortality is to be reduced in any community.

The house staffs were associated with the greatest number of preventable deaths. The largest number in non-teaching municipal hospitals.

The book is worthy of study by all obstetricians and pediatricians.

R.S.S.